

1 ANN MILLER RAVEL, County Counsel (S.B. #62139)
2 MIGUEL MÁRQUEZ, Assistant County Counsel (S.B. #184621)
3 TAMARA LANGE, Lead Deputy County Counsel (S.B. #177949)
4 JENNIFER S. SPRINKLES, Deputy County Counsel (S.B. #211493)
5 OFFICE OF THE COUNTY COUNSEL
6 70 West Hedding Street, East Wing, Ninth Floor
7 San Jose, California 95110-1770
8 Telephone: (408) 299-5900
9 Facsimile: (408) 292-7240

10 Attorneys for Defendants
11 COUNTY OF SANTA CLARA AND
12 THE SANTA CLARA COUNTY
13 PUBLIC HEALTH DEPARTMENT

14 UNITED STATES DISTRICT COURT
15
16 NORTHERN DISTRICT OF CALIFORNIA
17

18 CALIFORNIA RESTAURANT
19 ASSOCIATION,

20 Plaintiff,

21 v.

22 THE COUNTY OF SANTA CLARA and
23 THE SANTA CLARA COUNTY PUBLIC
24 HEALTH DEPARTMENT,

25 Defendants.

No. C08-03685 CW

**DECLARATION OF DR. MARTIN
FENSTERSHEIB IN OPPOSITION TO
PLAINTIFF'S MOTION FOR
DECLARATORY RELIEF AND A
PRELIMINARY INJUNCTION**

Hearing Date: August 28, 2008
Time: 2:00 p.m.
Dept.: Ctrm 2, 4th Floor

1 I, Dr. Martin Fenstersheib, declare as follows:

2 1. I have personal knowledge of the matters stated herein, except for those matters set
3 forth on information and belief, which I believe to be true, and if called to testify, I can and will
4 testify competently as to all matters set forth herein.

5 2. I am the Health Officer of the Department of Public Health (the "Department") of the
6 County of Santa Clara (the "County"). I have held this position since 1994. I am also the Acting
7 Director of the Department. A copy of my *curriculum vitae* is attached hereto as Exhibit A.

8 3. State law vests the Board of Supervisors with the power to preserve and protect the
9 public health in the unincorporated territory of the County by adopting ordinances, regulations and
10 orders not in conflict with general laws.¹

11 4. Pursuant to § A18-10 of the Santa Clara County Ordinance Code ("Ordinance Code"),
12 the Health Officer shall observe and enforce all orders and standards pertaining to public health
13 which are adopted by the Board of Supervisors. This responsibility is in addition to all the duties
14 prescribed by state statutes and regulations. A core function of the Health Officer and the
15 Department is to conduct health assessments and determine factors that negatively affect the health of
16 County residents.

17 5. Pursuant to § A18-11 of the Ordinance Code, the County Health Officer has the
18 authority to act as the Health Officer for the fifteen cities within Santa Clara County. By resolution
19 and ordinance all fifteen cities have authorized the County Health Officer to act as health officer
20 within their jurisdiction. I will be meeting with the cities to encourage them to adopt the County's
21 menu labeling ordinance within each city.

22 6. Because of the importance of the public health risk caused by obesity and poor
23 nutrition, I participated in all aspects of determining the need for Ordinance NO. NS-300.793, which
24 amended Division A18 of the Ordinance Code of the County of Santa Clara by adding a new Chapter
25 XXII to provide for menu labeling in chain restaurants ("Ordinance 300.793" or "Menu Labeling
26

27 ¹ Cal. Health & Saf. Code § 101025.
28

Ordinance”), and I am submitting this declaration in opposition to the California Restaurant Association’s (“CRA”) motion for declaratory relief and a preliminary injunction.

I. OBESITY IS EPIDEMIC IN THE U.S., CALIFORNIA, AND SANTA CLARA COUNTY

7. The epidemic of overweight and obesity have become the fastest growing and most daunting public health challenge in the United States today. The Centers for Disease Control and Prevention (“CDC”) uses the terms “overweight” and “obesity” as “labels for ranges of weight that are greater than what is generally considered healthy for a given height.”² An overweight and obesity epidemic currently damages the health of many Americans, including residents of Santa Clara County.³ Over the last 25 years, obesity rates have doubled among U.S. adults and tripled among children and teens.⁴ In the last decade alone, obesity rates have increased in *every* state in the nation.⁵ In 1995, less than 20% of adults were obese in each of the fifty states. Just ten years later in 2005, less than 20% of adults were obese in only *four* states, while in seventeen states, 25% or more of adults were obese.⁶ In California, the percentage of obese adults has doubled to 23%, and more than one third of children are overweight or at risk of being overweight.⁷ A comparison of the obesity trend in just one year – from 2006 to 2007 – shows a dramatic national increase in rates of obesity, including in California’s immediate neighbors, Oregon and New Mexico:

² The Centers for Disease Control and Prevention, U.S. DEP’T OF HEALTH AND HUMAN SERVS., DEFINING OVERWEIGHT AND OBESITY, <http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm>. An adult who has a Body Mass Index (BMI) between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. *Id.*

³ *Id.*

⁴ Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. *Journal of the American Medical Association*. 295:1549-1555. 2006; *see also* *Pelman v. McDonald’s Corp.*, 237 F. Supp. 2d 512, 519-20 (S.D.N.Y. 2003) (summarizing rising obesity rates among adults and children).

⁵ U.S. DEP’T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL’S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001), <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

⁶ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), U.S. DEP’T OF HEALTH & HUMAN SERVS., U.S. OBESITY TRENDS 1985-2005, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm>.

⁷ CAL. DEP’T OF HEALTH SERVS., FINDINGS FROM THE 1999 CALIFORNIA CHILDREN’S HEALTHY EATING AND EXERCISE PRACTICES SURVEY (2004), <http://www.dhs.ca.gov/ps/cdic/cpns/research/download/calcheeps/CalCHEEPS-Low.pdf>.

Obesity Trends* Among U.S. Adults

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)

BRFSS, 1986



BRFSS, 2006

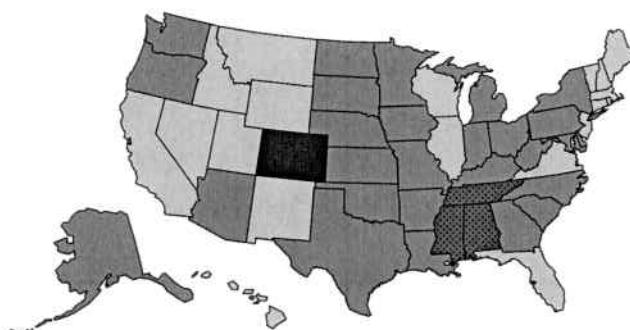


No Data <10% 10%-14%

No Data <10% 10%-14% 15%-19% 20%-24% 25%-29% $\geq 30\%$

Obesity Trends* Among U.S. Adults BRFSS, 2007

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)



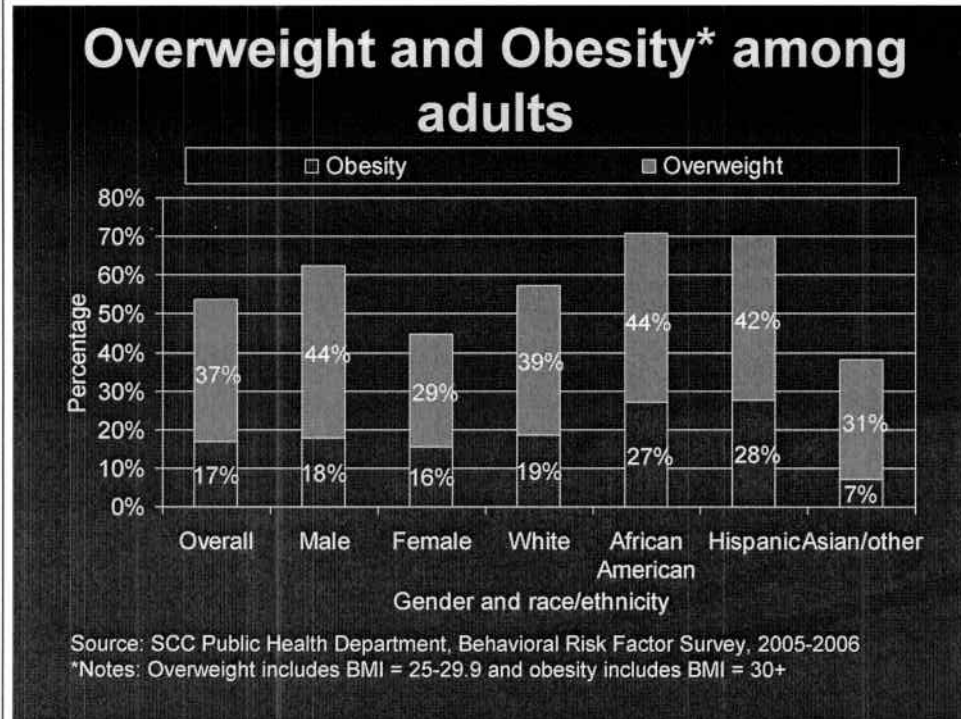
No Data <10% 10%-14% 15%-19% 20%-24% 25%-29% $\geq 30\%$



Source: Behavioral Risk Factor Surveillance System, CDC.

8. According to the Santa Clara County Behavioral Risk Factor Survey (BRFSS), County adults showed a trend that mirrors the national trends. In 2000, 52% of County adults were either

obese or overweight.⁸ By 2005, that proportion had increased to 53.8%. Certain minority groups in the County face dramatically higher obesity and overweight rates. In 2005, over 70% of County adult Latinos and African Americans reported a Body Mass Index (BMI) compatible with obesity or overweight. In addition, County Hispanics reported a 7% increase in the prevalence of overweight and obesity during this 5 year period, which was the greatest increase.⁹



9. County children also are impacted by this health crisis. According to data from the California Healthy Kids Survey (CHKS) for all the school districts in Santa Clara County, 26% of high and middle school children in Santa Clara County were either overweight or at risk of becoming overweight.¹⁰ This proportion is also higher among minorities: Latino (37%) and African American (33%) students were overweight or at risk of becoming overweight compared to one in five for other

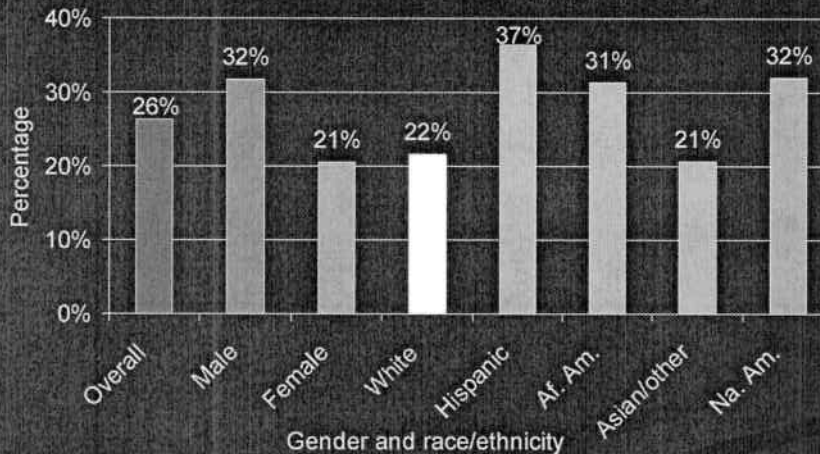
⁸ Santa Clara County 2000 and 2005 Behavioral Risk Factors Survey (BRFSS), www.sccphd/statistics2.

⁹ *Id.*

¹⁰ Santa Clara County 2005-2006 California Healthy Kids Survey (CHKS), www.sccphd.org/statistics2.

ethnic groups.¹¹ Researchers note that 50% of children who are overweight remain overweight as adults, contributing to increased cases of diabetes, heart disease and other chronic diseases.¹²

Middle and high school students who are overweight or at risk of being overweight*



Source: SCC Public Health Department, California Healthy Kids Survey, 2005-2006

*Notes: Overweight or at risk of being overweight includes BMI \geq 85th percentile

10. On June 24, 2008, the Board of Supervisors of the County of Santa Clara voted unanimously to adopt Ordinance 300.793. The Ordinance mandates that chain restaurants with 14 or more locations in California post calorie and nutrition information on menus and menu boards to enable the citizens of Santa Clara County to make more informed dining choices.

The County's Menu Labeling Ordinance will give residents of Santa Clara County the caloric content and nutritional components of food prepared, purchased, and eaten outside the home, enabling them to make healthy choices to prevent and/or manage chronic diseases associated with being overweight or obese. This information is sorely needed and not presently available to most consumers. By

¹¹ *Id.*

¹² UNIV. OF CAL., AGRIC. & NATURAL RES., NUTRITION ONLINE MEDIA KIT, FACT SHEET, <http://news.ucanr.org/mediakits/nutrition/nutritionfactsheet.shtml> (citing Univ. of Cal., Berkeley, Cooperative Extension, Dep't of Nutritional Sci., *Childhood Overweight, A Fact Sheet for Professionals* (2000)).

1 mandating that restaurants post nutritional information on menus and menu boards, Ordinance
2 300.793 will allow County residents dining in chain restaurants to make more informed decisions that
3 may decrease their risk of the severe negative health effects associated with being overweight or
4 obese. Access to such information is most beneficial at the point of purchase and is of particular
5 value to parents trying to help their children eat wisely and to persons with specific dietary needs.
6 Chain restaurants are an appropriate focus for menu labeling regulations because chain restaurants
7 typically have standardized menus, recipes and preparation methods that allow for accurate
8 nutritional disclosures. The Ordinance will also likely lead restaurants (as already evidenced in
9 NYC), to reformulate their menus to include healthier options.
10

11 **II. OBESITY, EXCESS WEIGHT AND POOR NUTRITION CAUSE A WIDE RANGE**
12 **OF SERIOUS HEALTH PROBLEMS FOR SANTA CLARA COUNTY ADULTS AND**
13 **CHILDREN**

14 11. The health problems associated with being overweight or obese have caused a public
15 health crisis in Santa Clara County. Overweight or obese individuals are at increased risk for type 2
16 diabetes, heart disease, stroke, arthritis, gall bladder disease, osteoarthritis, sleep apnea, respiratory
17 problems, depression, and colon, breast, endometrial, and prostate cancers. A survey in Santa Clara
18 County found a strong correlation between overweight and obesity with certain chronic diseases.¹³
19 Adults who were obese or overweight were three times more likely to have been diagnosed with high
20 blood pressure and 1.8 times more likely to have a diagnosis of arthritis compared to those who were
21 not obese or overweight.¹⁴ An estimated 22% of County adult residents have high blood pressure,
22 which requires limiting their sodium intake. In addition, 33% of County adults have high cholesterol
23 and should restrict their fat intake.¹⁵
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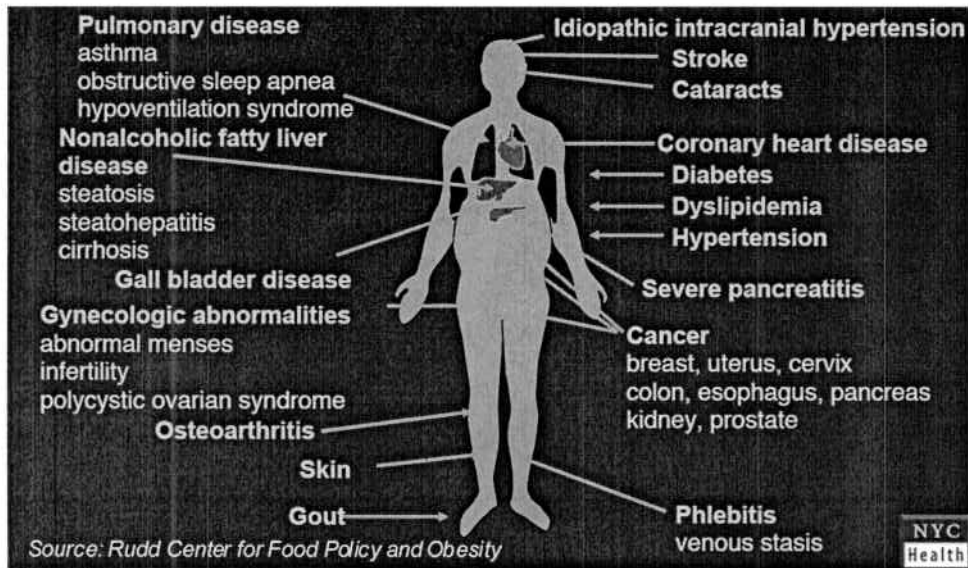
25 ¹³ Santa Clara County 2000 Behavioral Risk Factors Survey (BRFSS),
www.sccphd.org/statistics2.

26 ¹⁴ Santa Clara County 2005 Behavioral Risk Factors Survey (BRFSS),
www.sccphd.org/statistics2.

27 ¹⁵ *Id.*
28

Medical Complications of Obesity

Almost every organ system is affected



12. Obesity and overweight are associated with large decreases in life expectancy.¹⁶ In fact, due to the rapid increase in obesity, today's children may – for the first time in modern history – have shorter lives than their parents.¹⁷ In addition, it is now estimated that more than a third of children who were born in 2000, are at very high risk for developing type II diabetes in their lifetime (girls: 38% boys 33%). According to the Surgeon General: “Unhealthy dietary habits and sedentary behavior together account for approximately 300,000 deaths every year.”¹⁸ A 2005 study by the Centers for Disease Control and Prevention (CDC) estimated that approximately 112,000 deaths are associated with obesity each year in the United States, making obesity the second leading contributor

¹⁶ Peeters A, Barendt JJ, Willekens F, Mackenbach JP, Marnun A, Bonneux L. Overweight and obesity by middle age are associated with shortened lifespan. *Annals of Internal Medicine*. 2003; 24-32.

¹⁷ Olshansky SJ, Passaro DJ, Hershow RC, et al., A Potential Decline In Life Expectancy In The United States In The 21st Century, *New England Journal of Medicine*, March 17, 2005; 352(11):1138-1145.

¹⁸ U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001].

to premature death, second only to tobacco.¹⁹ Of the top 15 leading causes of deaths in Santa Clara County, five are associated with obesity or diabetes, as denoted by an "*" in the following table.

TOP 15 LEADING CAUSES OF DEATHS IN SANTA CLARA COUNTY

Rank		2000		2005		2000-2005 Absolute Change
		Frequency	Percent	Frequency	Percent	
1	Malignant Neoplasms (Cancer) *	2082	23.7%	2278	26.1%	9.4%
2	Diseases of Heart *	2550	29.0%	2117	24.3%	-17.0%
3	Cerebrovascular diseases (Stroke)*	728	8.3%	571	6.6%	-21.6%
4	Chronic Lower Respiratory Diseases	440	5.0%	454	5.2%	3.2%
5	Alzheimer's disease	169	1.9%	401	4.6%	137.3%
6	Diabetes mellitus*	239	2.7%	338	3.9%	41.4%
7	Influenza and pneumonia	356	4.0%	332	3.8%	-6.7%
8	Accidents -unintentional injuries	324	3.7%	327	3.8%	0.9%
9	Chronic Liver Disease and Cirrhosis	150	1.7%	156	1.8%	4.0%
10	Essential (primary) hypertension and hypertensive renal disease*	72	0.8%	127	1.5%	76.4%
11	Intentional self-harm -suicide	117	1.3%	107	1.2%	-8.5%
12	Assault -homicide	43	0.5%	47	0.5%	9.3%
13	Nephritis, nephrotic syndrome and nephrosis	60	0.7%	42	0.5%	-30.0%
14	Septicemia	33	0.4%	41	0.5%	24.2%
15	Pneumonitis due to solids and liquids	37	0.4%	26	0.3%	-29.7%
	All other causes	1402	15.9%	1353	15.5%	-3.5%
	Group Total	8802	100.0%	8717	100.0%	-1.0%

A. The Related Epidemics of Obesity and Diabetes Cause Devastating Health Consequences

13. Increasing obesity rates have led to increasing diabetes rates. Indeed, being overweight or obese is the main risk factor for diabetes. As of 2005, 15.8 million Americans had diabetes, almost triple the number from 1980.²⁰ Between 50% and 80% of diabetes cases are associated with obesity, unhealthy eating and physical inactivity.²¹ There has been a steady rise of diabetes in California in recent years. In 2001, the prevalence of diabetes among adults over 18 years

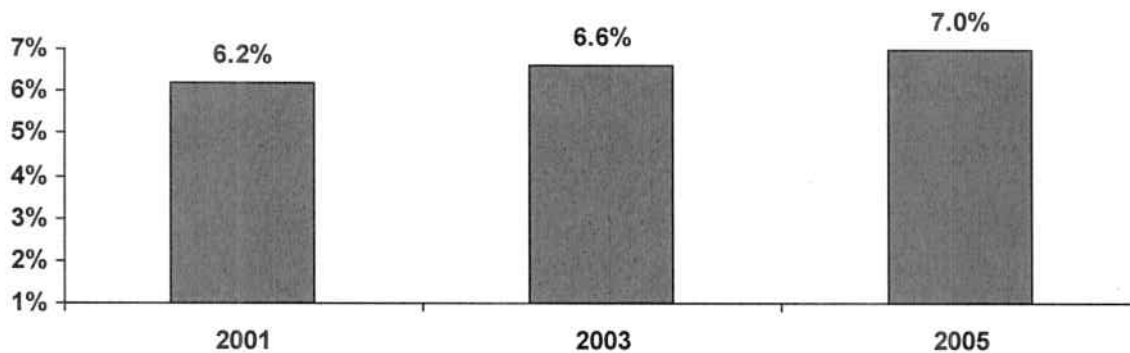
¹⁹ Flegal K, Graubard B, Williamson D, Gail M, Excess Deaths Associated with Underweight, Overweight, and Obesity, *Journal of the American Medical Association*. 293: 1861, 1861-67 (2005).

²⁰ NAT'L CTR. FOR HEALTH STATISTICS, CDC, NAT'L DIABETES SURVEILLANCE SYSTEM, PREVALENCE OF DIABETES (1980-2005), <http://www.cdc.gov/diabetes/statistics/prev/national/tablepersons.htm>.

²¹ Hu FB, Manson JE, Stampfer MJ, Colditz G, Liu S, Solomon CG, Willett WC, Diet, lifestyle, and the risk of type 2 diabetes mellitus in women. *New England Journal of Medicine*. 2001; 345:790-797 (2001).

old was 1.5 million or 6.2%. In 2005, over 1.8 million people (7.0%) have been diagnosed with diabetes.²² The total number of cases also increased from 1,071,000 in 1994 to 1,868,000 in 2005.²³

Diabetes Prevalence by Year, Adults Age 18 and Over, California 2001-2005



Source: 2001, 2003, 2005 California Health Interview Surveys.

14. In Santa Clara County, approximately 80,660 people over 20 years old, or 6.6% of the population have been diagnosed with diabetes.²⁴

15. Diabetes has devastating consequences. In 2005, diabetes ranked as the sixth leading cause of death in the County. Diabetes was identified as the major cause of death for 3% of the decedents, with a total number of 338 deaths.²⁵ Between 2000 and 2005 the number of deaths due to diabetes increased by 41%. Similarly, deaths due to essential hypertension increased by 76% during those years.

B. Obesity And Diabetes Are Responsible for Soaring Health Care Costs

16. Obesity and diabetes are generating extraordinary financial costs in the United States and in Santa Clara County. Between 1987 and 2001, rising obesity rates and obesity related illnesses

²² UCLA CTR. FOR HEALTH POLICY RESEARCH, 2005 CALIFORNIA HEALTH INTERVIEW SURVEY, <http://www.chis.ucla.edu/>.

²³ County Level Estimates of Diagnosed Diabetes- Percentage of Adults in California by Natural Breaks, 2005 CDC, National Center for Chronic Disease Prevention and Health Promotion, 2007.

²⁴ *Id.*

²⁵ *Id.*

accounted for more than one-quarter of the growth in health care spending in the United States.²⁶ A 2002 study by the American Diabetes Association estimates that direct and indirect costs of diabetes were \$132 billion, which means that one out of every ten health care dollars spent in the U.S. is spent on diabetes and its complications.²⁷ These sums are far larger if other obesity-related diseases and lost productivity are taken into account. Health care spending among people who are obese has been estimated to be 37% higher than among those with normal weight, and increases in the proportion of and spending on obese people relative to people of normal weight accounted for 27% of the rise in inflation-adjusted per capita health care spending between 1987 and 2001.²⁸

17. Diabetes also costs state and local governments huge sums. The Juvenile Diabetes Research Foundation International estimated that diabetes cost California alone about \$20.4 billion in 2004 in direct and indirect costs.

18. According to the California Department of Health Services, the obesity epidemic cost the private and public sectors in California an estimated \$28 *billion* in direct medical expenses, workers' compensation, and lost productivity in 2005.²⁹ In Santa Clara County, the total cost of hospital admissions with obesity-coding was \$140 million dollars from 2000-2002.³⁰

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²⁶ Thorpe KE, Florence CS, Howard DH, Joski P. The Impact of Obesity on Rising Medical Spending. *Health Affairs* (Millwood) 2004 Jul-Dec; Suppl Web Exclusives:W4-480-6.

²⁷ American Diabetes Assn., Economic Costs of Diabetes in the U.S. in 2002, *Diabetes Care* 23:3 (March 2003).

²⁸ Thorpe KE, Florence CS, Howard DH, Joski P. The Impact of Obesity on Rising Medical Spending. *Health Affairs* (Millwood). 2004 Jul-Dec; Suppl Web Exclusives:W4-480-6.

²⁹ CAL. DEP'T OF HEALTH SERVS., THE ECONOMIC COSTS OF PHYSICAL INACTIVITY, OBESITY, AND OVERWEIGHT IN CALIFORNIA ADULTS: HEALTH CARE, WORKERS' COMPENSATION, AND LOST PRODUCTIVITY (2005), <http://www.dhs.ca.gov/cdic/cpns/press/downloads/costofObesityToplineReport.pdf>.

³⁰ Healthy Silicon Valley-Hospital Council of Northern and Central California Santa Clara County Conference - Hospital Task Force Report, 2006, http://www.healthysiliconvalley.org/pdflib/press/press06/Hospital_Task_Force2.pdf.

III. CHAIN RESTAURANT MENU BOARDS WITHOUT CALORIE INFORMATION AND MENUS WITHOUT CALORIES, FAT AND SODIUM ARE MISLEADING AND DECEPTIVE

19. I have read and reviewed the Declaration of Mitchell H. Katz M.D. in Opposition to the Plaintiff's Motion for Declaratory Relief and a Preliminary Injunction in *California Restaurant Association v. The City and County of San Francisco and the San Francisco Department of Public Health*, Case No. C08-3247 CW. I am familiar with the body of research on which he relies. Dr. Katz's Declaration accurately reflects the research summarized in paragraphs 20 through 70 of this declaration, and I hold the same opinions expressed by Dr. Katz therein. The Katz Declaration is attached as Exhibit B.

20. An August 2008 study by the Dr. Robert C. and Veronika Atkins Center for Weight and Health at the University of California, Berkeley (the "Center"), entitled Potential Impact of Menu Labeling of Fast Foods in California, reviewed the leading data in the field relevant to menu labeling. A copy of that report is attached hereto as Exhibit C. The Center reports that consumers routinely underestimate calories in food and that, without menu labeling, consumers are unlikely to be able to identify the wide range of calories in similar products.³¹ The study compared the calorie content of burgers at McDonalds and found that the nine burger choices ranged from 250 to 740 calories.³² The study concluded that without either portion size or calorie information on menu boards, a consumer would find it difficult if not impossible to accurately estimate the calorie content of the menu items.³³ In addition, the study reported that, in California, 84% of a representative sample of adults support requiring fast-food and chain restaurants to post nutritional information on menus and menu boards. The traditional public health nutritional messages, which focus on limiting high calorie and poor nutritional foods, must be supplemented with information about actual nutritional content at the point of purchase to enable consumers to make healthy choices.

³¹ Center for Weight and Health, *Potential Impact of Menu Labeling of Fast Foods in California*, August 2008. www.cnr.berkeley.edu.

³² *Id.*

³³ *Id.*

A. Children's Menus in Chain Restaurants Are Deceptively High in Calories, Sodium and Fat

21. An August 2008 report on the 25 largest revenue-generating chain restaurants in the United States found that children's menus are consistently high in calories (93%) and sodium (86%). The report also found that 45% of children's meals in the top chain restaurants exceed the recommendations for saturated and trans fat, which can raise blood cholesterol levels and increase heart disease.³⁴ For example, parents would be surprised to learn that a Burger King children's meal of a double cheeseburger, fries and chocolate milk has 910 calories. According to the August report, soft drinks are offered with 95% of the children's meals of the largest chain restaurants.³⁵ A copy of that report is attached hereto as Exhibit D. Because children's meals are advertised as "meals," many parents are likely to assume that portion sizes are calculated to allow children to eat three meals a day. Yet at leading chain restaurants, 93% of children's meals exceed the calorie limit. At the top three chain restaurants by revenue – McDonald's, Burger King and KFC=92-100% of the children's meal combinations exceeded the calorie limit. The study concluded that providing calorie information on menus and menu boards will help parents to identify which options are healthier. Making information about caloric values and fat and sodium content available to consumers will reduce consumer confusion and deception and increase parents' ability to make healthy choices for their children.

22. A 2005 UCLA study looked at the sugary drink consumption of children in California and found that two-thirds (66.3%) of California adolescents drink soda and nearly half (48%) eat fast food on a daily basis. Low income adolescents ages 12-17 drink more soda and sugary drinks (1.5 to 1.6 per day) than those of higher incomes (1.2 per day). African-American and Latino adolescents drink the greatest amount of soda and sugary drinks per day (2 and 1.7 per day respectively). Teens

³⁴ Center for Science in the Public Interest, *Kids Meals: Obesity on the Menu*, August 2008. <http://cspinet.org/new/pdf/kidsmeals-report.pdf>.

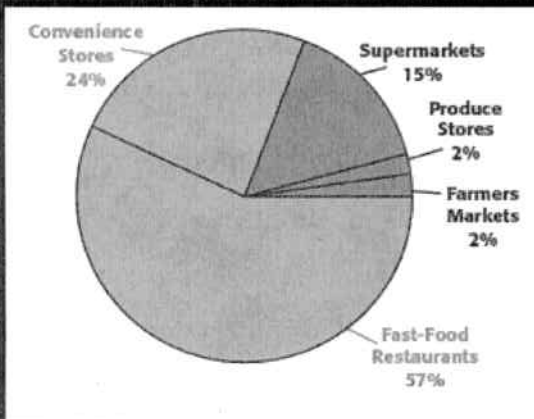
³⁵ *Id.*

who eat fast food as part of a daily routine also tend to drink more soda. Those who eat fast food daily “drink an additional soda for each time they eat fast food beyond the first instance.”³⁶

B. Chain Restaurants Often Target Children With Their Advertisements

23. As explained in the Katz Declaration in paragraphs 61-63, chain restaurants make extensive use of advertising to appeal to children. A Federal Trade Commission study of 2006 expenditures and activities of 44 food and beverage companies found that Quick Service Restaurants reported spending nearly \$294 million on marketing to youth, divided evenly between children and adolescents.³⁷

Searching for healthy food



In SCC, there are more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors, for a Retail Food Environment Index (RFEI)* of 4.32 (CA RFEI is 4.18)

Source: California Center for Public Health Advocacy, Searching for Healthy food, The Food Landscape in Santa Clara County, January 2007

*RFEI=(#fast food restaurants + #convenience stores)/(#supermarkets + #produce stores + #farmers markets)

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³⁶ UCLA CTR. FOR HEALTH POLICY RESEARCH, HASTERT, *MORE CALIFORNIA TEENS CONSUME SODA AND FAST FOOD EACH DAY THAN FIVE SERVINGS OF FRUITS AND VEGETABLES*, SEPTEMBER 2005. WWW.HEALTH.POLICY.UCLA.EDU/PUBS/FILES/TEEN_FASTFOOD_PB.PDF.

³⁷ Federal Trade Commission, *Marketing Food to Children and Adolescents: A Review of Industry Expenditures, Activities, and Self Regulation*, July 2008. www.ftc.gov/os/2008/07/p064504foodmktgreport.pdf.

C. The Increasing Number of Chain Restaurants Makes High Calorie Food More Available to County Residents

24. Between 2005 and 2009, the number of fast food establishments is projected to increase from 266,300 to 287,437 establishments.³⁸ In Santa Clara County, there are more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors.³⁹ Fast food restaurants are more likely to be found in low-income neighborhoods and near low-income schools.⁴⁰ As explained in the Katz Declaration in paragraphs 25- 35, the increasing number of chain restaurants, which serve food that is easily available, inexpensive and high in calories, has facilitated the trend of obesity and overweight.

IV. ORDINANCE 300.793 IS AN IMPORTANT PART OF THE COUNTY'S BROADER EFFORT TO REDUCE OVERWEIGHT AND OBESITY

25. My expert opinion and the policy of the Public Health Department of Santa Clara County hold that the best approach to reversing the obesity epidemic among our residents is to use all the strategies and techniques that are available to us within our County system of government. The Menu Labeling Ordinance is an important strategy in a multi-pronged approach designed to improve consumer education, reduce consumer confusion and deception, and empower individuals to make healthier choices. The Public Health Department and other Santa Clara County Departments, including Valley Medical Center (the County hospital) and Parks & Recreation, are working together to increase public awareness and knowledge about the importance of healthy eating and regular physical activity as part of a healthy lifestyle. The County is also creating environments that support healthy lifestyles where people live, work, learn and play throughout the County. To this end, the County has existing programs to:

³⁸ C. Barnes & Co. 2008 Barnes Reports: U.S. Fast Foods Restaurants Industry (NAICS 72221). 2007.

³⁹ California Center for Public Health Advocacy, Searching for Healthy Food, The Food Landscape in Santa Clara County, January 2007.

⁴⁰ Center for Weight and Health, *Potential Impact of Menu Labeling of Fast Foods in California*, August 2008. www.cnr.berkeley.edu.

- Integrate primary prevention into medical services offered through Valley Medical Center and ambulatory clinics, such as the Pediatric Healthy Lifestyles Clinic offering education and treatment for pediatric patients who are overweight or at risk of becoming overweight.
- Coordinate the Early Childhood Feeding Practices Collaborative, an initiative designed to address pediatric obesity, through a systematic approach integrating healthcare and daycare settings.
- Support implementation and monitoring of school wellness policies and establishment of coordinated school health councils in school districts throughout Santa Clara County.
- Conduct community assessments on nutrition and physical activity environments in local neighborhoods and engage residents in helping to create environmental changes, such as farmers' markets, community gardens, sidewalks and bike paths, to support the health of local residents.
- Increase access to affordable, healthy foods in neighborhoods with limited access.
- Coordinate countywide Healthy Trails initiative designed to encourage individuals, families, worksites, and community groups to engage in physical activity using trails located in the County Parks.
- Implement County worksite wellness programs serving a workforce of over 17,000 employees (largest employer in Santa Clara County).
- Adopt policies to support healthy food options at meeting and events.
- Provide worksite wellness trainings and tools to support healthy lifestyle behaviors through organizational practice and policy changes in small and large worksites, including in schools, healthcare agencies, community-based organizations, and other governmental businesses.

- Develop and implement social marketing campaigns designed to encourage breastfeeding, eating fruits and vegetables, and getting regular physical activity.

26. The Department and the County are undertaking a broad range of measures to help residents of the County prevent or reverse weight gain. The need for additional actions to halt the obesity epidemic is no reason to refrain from taking action on posting nutrition information.

V. ORDINANCE 300.793 IS NECESSARY TO REDUCE CONSUMER CONFUSION AND DECEPTION AND TO ADVANCE PUBLIC HEALTH IN SANTA CLARA COUNTY

27. Based on my expertise as a physician and as a Health Officer and my familiarity with the body of research described above, in the attached studies and in the Katz Declaration, it is my expert opinion that implementation of Ordinance 300.793 will directly advance the County and the Department's goals of reducing consumer confusion and deception about the nutritional content of food sold at chain restaurants. Implementation of Ordinance 300.793 is necessary to combat the serious public health crisis resulting from obesity. Many chain restaurants provide no nutritional information to consumers and only a few provide that information at the point of decision making. The increasing rate of overweight and obesity, the harm to individuals, the community and the public from obesity-related illnesses and the clear relationship between eating at fast-food restaurants and increased caloric intake all support the necessity of Ordinance 300.793 to advance public health and to reduce consumer confusion and deception to make healthy choices when reviewing chain restaurant menus and menu boards.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge.

Executed on August 19, 2008 at San Jose.

By: Martin Fensterheib, M.D.
MARTIN FENSTERSHEIB, M.D.

CURRICULUM VITAE

Martin Darryl Fenstersheib, MD, MPH
976 Lenzen Avenue
San Jose, California 95126

Revised: August 2007

Professional Experience

1994 - Present	Health Officer, Santa Clara County Medical Director, Santa Clara County Public Health Department, San Jose, CA
May 2003	Select Group on Homeland Security to Israel, Project Interchange
1993 - 1994	Acting Health Officer, Santa Clara County Public Health Department, San Jose, CA
1989 - 1993	Deputy Health Officer, Santa Clara County Health Department, San Jose, CA
1989 - 1997	Chief, Disease Control and Prevention Division, Santa Clara County Public Health Department, San Jose, CA
1986 - 1993	STD Control Officer, Santa Clara County Health Department, San Jose, CA
1986 - 1993	Medical Director and Clinician, Santa Clara County HIV Early Intervention Clinic, San Jose, CA
1982 - 1986	Director, Well Baby Clinic, San Francisco Health Districts 1 and 2, San Francisco, CA Clinical Physician, Hispanic Children's Clinic, Mission Area, San Francisco Health Department, San Francisco, CA
1981 - 1982	La Clinica, Mexican Migrant Workers Clinic, Watsonville, CA
1980 - 1984	Ambulatory Division and Emergency Room, St. Lukes Hospital, San Francisco, CA Ambulatory Clinic, Kaiser Permanente Hospital, Oakland, CA Ambulatory Clinic, Kaiser Permanente Hospital, South San Francisco, CA Evening Unit Physician, Pediatric Oncology Unit, Pacific Medical Center, San Francisco, CA
1979 - 1980	Private Practice of Pediatrics, Greensboro, NC

Educational Background

1971 - 1975	Autonomous University of Guadalajara, Mexico; M.D.
1967 - 1971	Tulane University, New Orleans, Louisiana; B.S., Biology

Postdoctoral Training

1981 - 1982	Fellowship, Preventive Medicine, University of California, Berkeley, CA
1980 - 1981	Master of Public Health, Division Maternal and Child Health, University of California, Berkeley, School of Public Health, Berkeley, CA
1977 - 1979	Residency, Milwaukee Children's Hospital, Milwaukee, WI
1976 - 1977	Internship, Hospital of the Medical College of Pennsylvania, Philadelphia, PA

EXHIBIT A

Licensure and Certification

1987	American Board of Preventive Medicine
1985	American Board of Pediatrics
1984 - 2000	Physician Assistant Supervisor, California
1980 - Present	State License, California (A35836)
1976 - Present	State License, Pennsylvania

Professional Affiliations

2006 – Present	Senior Fellow, American Leadership Forum of Silicon Valley, California
2006 – Present	Preparedness Project Advisory Committee, Center for Infectious Disease Research and Policy (CIDRAP), Pew Charitable Trusts
2005 – Present	Board of Directors, National Association of County and City Health Officials
2004 – Present	Chair, Chronic Disease Committee, National Association of County and City Health Officials
2003 – Present	Member, American Cancer Society, Colon Cancer Free Zone Project
2003 – Present	Member, South Bay Emergency Medical Directors Association
2002 – Present	Member, Approval Authority, State of California Office of Homeland Security Grant Programs, (Chair 2006 – 2007)
1998 – Present	Member, California Medicine and Public Health Initiative
1998 – Present	Member, Bay Area Terrorism Working Group, California
1998 – Present	Member, Metropolitan Medical Task Force, San Jose, CA
1998 – Present	Co-Chair, Traffic Safe Communities Network, Santa Clara County Public Health Department
1996 – Present	Member, Board of Directors, California Conference of Local Health Officers
1995 – Present	Member, HIV Health Services Planning Council, Santa Clara County, CA
1995 – Present	Member, California Medical Association
1995 – Present	Vice President for Community Health, Santa Clara County Medical Association
1994 - Present	Chairman, Department of Community Health and Preventive Medicine, Santa Clara Valley Medical Center, San Jose, CA
1994 – Present	Member, Association of Bay Area Health Officials, California
1993 – Present	Staff Physician, Santa Clara Valley Medical Center, San Jose, CA
2004 – 2006	Co-chair, Strategic Planning Committee, California Department of Health Services
2003 – 2005	Member, Forensic Epidemiology Project: Joint Training for Law Enforcement and Public Health Officials on Investigative Responses to Bioterrorism
2000 – 2001	Member, California Hepatitis C Strategic Planning Group, State Department of Health Services
2000 – 2003	Member, Bioterrorism and Emergency Response Advisory Committee, National Association of County and City Health Officials
1999 – 2001	Member, American Heart Association Stroke Task Force, San Jose, CA
1998 – 1999	President, Health Officers Association of California

1998 – 1999	Member, Mayor's Quality of Life Task Force, San Jose, CA
1997 – 1999	President, California Conference of Local Health Officers
1996 – 2003	Member, California HIV Planning Group, State Department of Health Services, Office of AIDS
1996 – 1999	Member, American Red Cross Medical Advisory Committee, Northern California Region, San Jose, CA
1988 – 1990	Chairperson, State STD Control Association
1988 – 1990	Member, Board of Directors, VNA Inc., San Jose, CA
1987 – 2000	Co-Chair HIV/AIDS Task Force, Santa Clara County Medical Association, San Jose, CA
1987 – 1989	Director, Santa Clara County AIDS Program, San Jose, CA
1981 – 1984	Consultant and Teacher, Public Health Nurses, Well Baby Care and Examinations, Yolo County and Santa Cruz County, CA VD Clinics, Berkeley City Health Department, Berkeley, CA

Professional Associations

1999 – Present	National Association of County and City Health Officials
1999 – Present	County Health Executives Association of California
1995 – Present	Santa Clara County Medical Association
1995 – Present	California Medical Association
1993 - Present	California Conference of Local Health Officers
1993 - Present	American College of Preventive Medicine, Fellow
1981 - Present	American Public Health Association
1985- 1988	American Academy of Pediatrics, Fellow
1982- 1984	Bay Area Physicians For Human Rights

Honors and Awards

October 2004	Recipient of the Francis C. Arrillaga Humanitarian Award for End of Life Care from Pathways Home Health and Hospice, Santa Clara County, CA
June 2003	Recipient of the Outstanding Contribution in Community Service from Santa Clara County Medical Association, CA

Publications/Studies

1. "Cost Benefit Analysis of Alpha-Feto Protein Screening" in conjunction with the Northern California Kaiser, Division of Genetics, 1982.
2. Job and Task Analysis, Concentrating on the Child Health and Disability Prevention Program, San Francisco Health Department, 1982.
3. Incidence Study of Chlamydia in the Population Pressing to the Central VD Clinic, Santa Clara County, 1985.
4. Francis D., Anderson R., Gorman M., Fenstersheib M., et al. Targeting AIDS Prevention and Treatment Toward HIV-1 Infected Persons. *JAMA* 1989; 262: 2572 -2576.

5. Morrow HW, Slaten DD, Reingold AL, Werner SB, Fenstersheib MD. Risk factors associated with a school-related outbreak of serogroup C meningococcal disease. *Pediatr Infect Dis J* 1990; 9:394 - 398.
6. Fenstersheib, M.D., Miller M., Diggins, C., Liska S., et al. Outbreak of Pontiac fever due to *Legionella anisa*. *Lancet* 1990; 336:35-7.
7. Kemper CA, Zolopa AR, Hamilton JR, Fenstersheib M, Bhatia G, and Deresinski SC. Prevalence of measles antibodies in adults with HIV infection: Possible risk factors for seronegativity. *AIDS* 1992; 6:1321-5.
8. Mohle-Boetani JC, Miller B, Halpern M, Fenstersheib M, et al. School-based screening for tuberculous infection. A cost-benefit analysis. *JAMA* 1995; 274:613-9.
9. Snyder DC, Mohle-Boetani JC, Palla B, Fenstersheib M. Development of a population-specific risk assessment to predict elevated blood lead levels in Santa Clara County, California. *Pediatrics* 1995; 96:643-8.
10. Katz MH, McFarland W, Guillin V, Fenstersheib M, et al. Continuing High Prevalence of HIV and Risk Behaviors Among Young Men Who Have Sex With Men: The Young Men's Survey in the San Francisco Bay Area in 1992 to 1993 and in 1994 to 1995. *J Acquir Immune Defic Syndr Hum Retroviral* 1998; 19:178-181.
11. Mohle-Boetani JC, Werner, SB, Abbott S, Fenstersheib M, et al. *Salmonella enteritidis* Infections from Shell Eggs: Outbreaks in California. *West J Med* 1998; 169:229-301.

DENNIS J. HERRERA, State Bar #139669
City Attorney
WAYNE SNODGRASS, State Bar #148137
FRANCESCA GESSNER, State Bar #247553
TARA M. STEELEY, State Bar #231775
Deputy City Attorneys
1 Dr. Carlton B. Goodlett Place
City Hall, Room 234
San Francisco, California 94102-4682
Telephone: (415) 554-4762
Facsimile: (415) 554-4699
E-Mail: francesca.gessner@sfgov.org

Attorneys for Defendant
CITY AND COUNTY OF SAN FRANCISCO

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

CALIFORNIA RESTAURANT
ASSOCIATION,

Plaintiff,

vs.

THE CITY AND COUNTY OF SAN
FRANCISCO AND THE SAN
FRANCISCO DEPARTMENT OF
PUBLIC HEALTH,

Defendants.

Case No. C08-3247 CW

**DECLARATION OF DR. MITCHELL
H. KATZ IN OPPOSITION TO
PLAINTIFF'S MOTION FOR
DECLARATORY RELIEF AND A
PRELIMINARY INJUNCTION**

Hearing Date: September 4, 2008
Time: 2 p.m.
Place: Ctrm 2, 4th Floor

I, Dr. Mitchell H. Katz, declare as follows:

1. I have personal knowledge of the matters stated herein, except for those matters set forth on information and belief, which I believe to be true, and if called to testify, I can and will testify competently as to all matters set forth herein.

2. I am the Director of Health for the Department of Public Health (the "Department") of the City and County of San Francisco ("the City" or "San Francisco"). I have held this position since 1997. A copy of my *curriculum vitae* is attached hereto as Exhibit A.

3. Pursuant to § 4.110 of the San Francisco City Charter ("Charter"), the Health Commission and the Department are charged with "provid[ing] for the preservation, promotion and protection of the physical and mental health of the inhabitants of the City and County" of San Francisco. A core function of the Department is to conduct health assessments and determine factors that negatively affect the health of San Francisco residents. The Department also enforces provisions of the San Francisco Health Code (the "Health Code") and other applicable laws regulating service of food directly to consumers in the City.

4. Because of the importance of the public health risk caused by obesity, I participated in all aspects of determining the need for Ordinance 40-08 ("Ordinance 40-08" or "Menu Labeling Ordinance"), and I am submitting this declaration in opposition to the California Restaurant Association's ("CRA") motion for declaratory relief and a preliminary injunction.

OBESITY IS EPIDEMIC IN THE U.S., CALIFORNIA, AND SAN FRANCISCO

5. An obesity epidemic currently damages the health of many Americans, including residents of San Francisco.¹ Over the last 25 years, obesity rates have doubled among U.S. adults and tripled among children and teens.² In the last decade alone, obesity rates have increased in *every* state

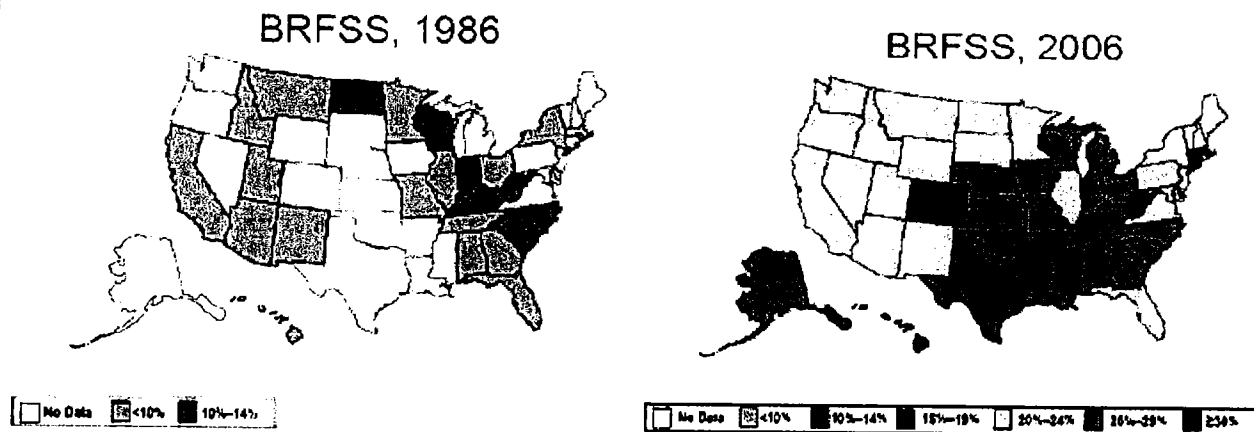
¹ The Centers for Disease Control and Prevention (CDC) uses the terms "overweight" and "obesity" as "labels for ranges of weight that are greater than what is generally considered healthy for a given height." CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), U.S. DEPT OF HEALTH AND HUMAN SERVS., DEFINING OVERWEIGHT AND OBESITY, <http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm>. An adult who has a Body Mass Index (BMI) between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. *Id.*

² Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. *Journal of the American Medical Association* (continued on next page)

in the nation.³ In 1995, less than 20% of adults were obese in each of the fifty states. Just ten years later in 2005, less than 20% of adults were obese in only *four* states, while in seventeen states, 25% or more of adults were obese.⁴ In California, the percentage of obese adults has doubled to 23%, and more than one third of children are overweight or at risk of being overweight.⁵

Obesity Trends* Among U.S. Adults

(*BMI ≥ 30 , or ~ 30 lbs. overweight for 5' 4" person)



(footnote continued from previous page)

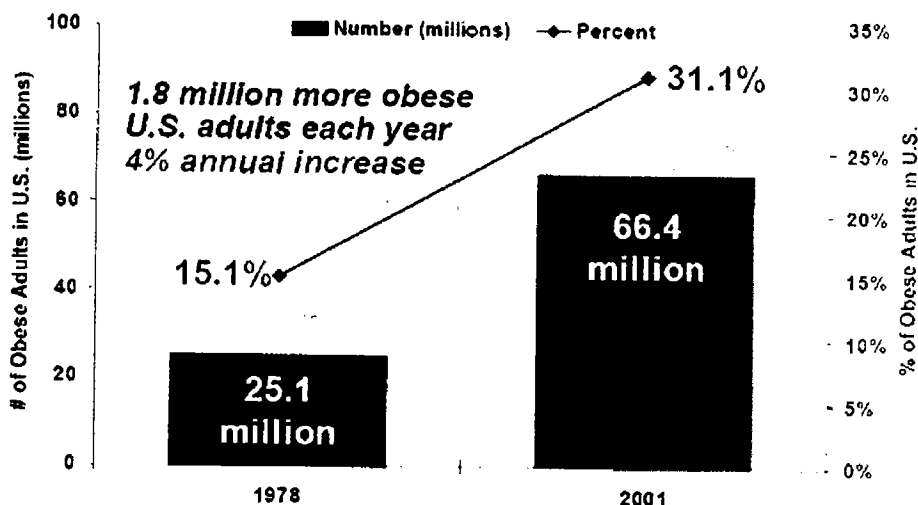
Association. 295:1549-1555. 2006; see also *Pelman v. McDonald's Corp.*, 237 F. Supp. 2d 512, 519-20 (S.D.N.Y. 2003) (summarizing rising obesity rates among adults and children).

³ U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001), <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

⁴ CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), U.S. DEP'T OF HEALTH & HUMAN SERVS., U.S. OBESITY TRENDS 1985-2005, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm>.

⁵ CAL. DEP'T OF HEALTH SERVS., FINDINGS FROM THE 1999 CALIFORNIA CHILDREN'S HEALTHY EATING AND EXERCISE PRACTICES SURVEY (2004), <http://www.dhs.ca.gov/ps/cdic/cpns/research/download/calcheeps/CalCHEEPS-Low.pdf>.

Obesity is Epidemic in the U.S.



Data from CDC

6. According to the California Health Interview Survey (CHIS), San Francisco mirrors the national trends. In 2001, 39.7% of San Franciscans were overweight or obese. By 2005, the percentage increased to 42.6%.⁶ Latino and African American individuals in San Francisco face particularly high obesity rates.⁷

7. San Francisco children are also impacted by this health crisis. According to data from 2004, 24% of school-age children in San Francisco are overweight.⁸ According to the 2005 Youth Risk Behavior Survey for the San Francisco Unified School District, 10.5% of high school students are overweight and 13.3% are at risk for becoming overweight. Researchers note that 50% of children who are overweight remain overweight as adults, contributing to increased cases of diabetes, heart disease and other chronic diseases.⁹

⁶ UCLA CTR. FOR HEALTH POLICY RESEARCH, 2005 CALIFORNIA HEALTH INTERVIEW SURVEY, <http://www.chis.ucla.edu/>.

⁷ *Id.*

⁸ CAL. CTR. FOR PUB. HEALTH ADVOCACY, THE GROWING EPIDEMIC: CHILD OVERWEIGHT RATES IN CALIFORNIA'S 10 LARGEST CITIES (2004), http://www.publichealthadvocacy.org/research_pdfs/10cities.pdf.

⁹ UNIV. OF CAL., AGRIC. & NATURAL RES., NUTRITION ONLINE MEDIA KIT, FACT SHEET, <http://news.ucanr.org/mediakits/nutrition/nutritionfactsheet.shtml> (citing Univ. of Cal., Berkeley, (continued on next page))

1 8. On March 18, 2008, after receiving overwhelming support for the proposal in the
2 public comment period, the San Francisco Board of Supervisors voted unanimously to adopt
3 Ordinance 40-08 ("the Ordinance"). The Ordinance mandates that chain restaurants with 20 or more
4 locations in California provide nutrition information on menus and menu boards to enable the citizens
5 of San Francisco to make more informed dining choices. The Mayor signed the Ordinance into law
6 on March 24, 2008.

7 9. The Department and I support the Menu Labeling Ordinance because it will give
8 residents of San Francisco the information they need to make healthy choices to prevent and/or
9 manage chronic diseases associated with being overweight. San Francisco is facing an obesity crisis.
10 This information is sorely needed and not presently available to most consumers. By mandating that
11 restaurants post nutritional information on menus and menu boards, Ordinance 40-08 will allow San
12 Francisco residents dining in chain restaurants to make more informed choices that can decrease their
13 risk of the severe negative health effects associated with being overweight. It will also likely lead
14 restaurants to reformulate their menus to include healthier options. These issues are discussed in
15 greater detail below, as are the specific contentions made in the declarations from McDonald's,
16 Burger King, and T.G.I. Friday's submitted by CRA.

17 **OBESITY AND EXCESS WEIGHT CAUSE A WIDE RANGE OF SERIOUS HEALTH**
18 **PROBLEMS FOR SAN FRANCISCO ADULTS AND CHILDREN**

19 10. The health problems associated with being overweight have caused a public health
20 crisis in San Francisco. Overweight or obese individuals are at increased risk for type 2 diabetes,
21 heart disease, stroke, arthritis, gall bladder disease, osteoarthritis, sleep apnea, respiratory problems,
22 depression, and colon, breast, endometrial, and prostate cancers. Obesity and overweight are
23 associated with large decreases in life expectancy.¹⁰ In fact, due to the rapid increase in obesity,

24 (footnote continued from previous page)

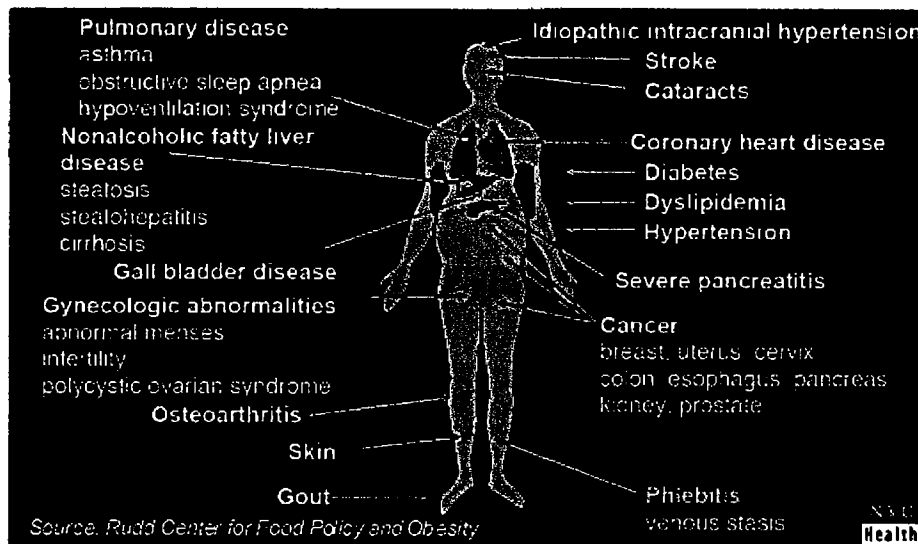
25 Cooperative Extension, Dep't of Nutritional Sci., *Childhood Overweight, A Fact Sheet for*
26 *Professionals* (2000)).

27 ¹⁰ Peeters A. Barendt JJ, Willekens F. Mackenbach JP, Mamun A, Bonneux L. Overweight
28 and obesity by middle age are associated with shortened lifespan. *Annals of Internal Medicine*. 2003;
24-32.

today's children may – for the first time in modern history – have shorter lives than their parents.¹¹ According to the Surgeon General: “Unhealthy dietary habits and sedentary behavior together account for approximately 300,000 deaths every year.”¹² A 2005 study by the Centers for Disease Control and Prevention (CDC) estimated that approximately 112,000 deaths are associated with obesity each year in the United States, making obesity the second leading contributor to premature death, behind only tobacco.¹³

Medical Complications of Obesity

Almost every organ system is affected



11. Based on a recent analysis of premature mortality in San Francisco¹⁴ and estimates of fractions of premature mortality attributable to overweight,¹⁵ being overweight ranks as the second

¹¹ Olshansky SJ, Passaro DJ, Hershow RC, et al., A Potential Decline In Life Expectancy In The United States In The 21st Century, *New England Journal of Medicine*, March 17, 2005; 352(11):1138-1145.

¹² U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001].

¹³ Flegal K, Graubard B, Williamson D, Gail M, Excess Deaths Associated with Underweight, Overweight, and Obesity, *Journal of the American Medical Association*. 293: 1861, 1861-67 (2005).

¹⁴ Aragón TJ, Lichtensztajn DY, Katcher BS, Reiter R, Katz MH., Calculating Expected Years Of Life Lost To Rank The Leading Causes Of Premature Death In San Francisco, San Francisco Department of Public Health (July 24, 2007), http://www.sfdph.org/dph/files/reports/StudiesData/CHE_Rpt07242007C.pdf.

1 leading cause of premature mortality among females and the third leading cause among males in San
 2 Francisco. As the following chart illustrates, nearly all of the top causes of premature death in San
 3 Francisco are attributable at least in part to poor diet and lack of exercise.

Rank	Underlying cause of death	YLLs	Deaths	Average YLL	Attributable in part to Diet/Exercise
Male					
1	Ischemic heart disease	9,854	1,103	8.9	•
2	HIV/AIDS	6,465	319	20.3	•
3	Lung, bronchus, and trachea cancers	4,134	387	10.7	•
4	Cerebrovascular disease	3,420	418	8.2	•
5	Hypertensive heart disease	3,379	287	11.8	••
Female					
1	Ischemic heart disease	6,721	1,017	6.6	•
2	Cerebrovascular disease	4,221	614	6.9	•
3	Lung, bronchus, and trachea cancers	3,376	326	10.4	•
4	Breast Cancer	2,975	222	13.4	•
5	Hypertensive heart disease	2,215	269	8.2	••

YLL = Years of Life Lost (measure of premature mortality)

•• = Percent attributable to diet and exercise estimated to be greater than 40%

• = Percent attributable to diet and exercise estimated to be between 10% and 40%

Source: analysis by SFDPH, Community Health Epidemiology,
 using state death statistical master files

20 Roughly a quarter of premature mortality in San Francisco from ischemic heart disease,
 21 approximately half of premature mortality from hypertensive heart disease, and nearly three-quarters
 22 of premature mortality from diabetes can be attributed to being overweight. Being overweight is also
 23 an important cause of premature mortality from stroke, diabetes, colon cancer, and breast cancer in

(footnote continued from previous page)

¹⁵ Ezzati M, Vander Hoorn S, Lopez AD, Danaei G, Rodgers A, Mathers CD, *et al.*,
 Comparative Quantification Of Mortality And Burden Of Disease Attributable To Selected Risk
 Factors, GLOBAL BURDEN OF DISEASE AND RISK FACTORS, 241-396 (1st ed. 2006).

1 San Francisco. Excess weight contributes to high blood pressure, which affects 23% of San
 2 Franciscans, and high cholesterol, which affects 20% of San Franciscans.¹⁶

3 12. Having excess sodium or saturated fat in one's diet also causes health problems. An
 4 estimated 23% of San Franciscans have high blood pressure, which requires them to limit their
 5 sodium intake. In addition, 20% of San Franciscans have high cholesterol and are advised to reduce
 6 their intake of saturated fat.

7 **A. The Related Epidemics of Obesity and Diabetes Cause Devastating Health**
 8 **Consequences**

9 13. Increasing obesity rates have led to increasing diabetes rates. Indeed, being
 10 overweight or obese is the main risk factor for diabetes.

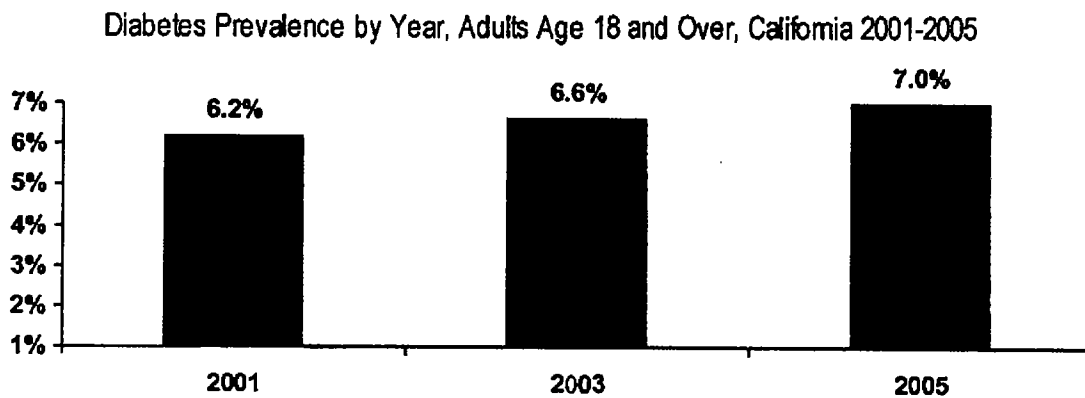
11 14. As of 2005, 15.8 million Americans had diabetes, almost triple the number from
 12 1980.¹⁷ Between 50% and 80% of diabetes cases are associated with obesity, unhealthy eating and
 13 physical inactivity.¹⁸ There has been a steady rise of diabetes in California in recent years. In 2001,
 14 the prevalence of diabetes among adults over 18 years old was 1.5 million or 6.2%. In 2005, over 1.8
 15 million people (7.0%) have been diagnosed with diabetes.¹⁹

22 ¹⁶ UCLA CTR. FOR HEALTH POLICY RESEARCH, 2005 CALIFORNIA HEALTH INTERVIEW
 23 SURVEY, <http://www.chis.ucla.edu/>.

24 ¹⁷ NAT'L CTR. FOR HEALTH STATISTICS, CDC, NAT'L DIABETES SURVEILLANCE SYSTEM,
 25 PREVALENCE OF DIABETES (1980-2005),
 26 <http://www.cdc.gov/diabetes/statistics/prev/national/tablepersons.htm>.

27 ¹⁸ Hu FB, Manson JE, Stampfer MJ, Colditz G, Liu S, Solomon CG, Willett WC, Diet,
 28 lifestyle, and the risk of type 2 diabetes mellitus in women. *New England Journal of Medicine*. 2001;
 345:790-797 (2001).

¹⁹ UCLA CTR. FOR HEALTH POLICY RESEARCH, 2005 CALIFORNIA HEALTH INTERVIEW
 SURVEY, <http://www.chis.ucla.edu/>.



Source: 2001, 2003, 2005 California Health Interview Surveys.

15. In San Francisco, approximately 6.3% of adults age 18 or older have been diagnosed with diabetes. According to the most recent data available, 16% of African Americans in San Francisco have been diagnosed with diabetes.²⁰

16. Diabetes has devastating consequences. According to data from 2004, diabetes is the ninth leading cause of premature death in San Francisco. Diabetes was also a contributing cause in 442 deaths in 2000 and 441 deaths in 2004 in the City.

²⁰ UCLA CTR. FOR HEALTH POLICY RESEARCH, 2005 CALIFORNIA HEALTH INTERVIEW SURVEY, <http://www.chis.ucla.edu/>.

Rank	Cause	Deaths	Crude Rate	Age-Adjusted Rate		
				Rate	LCI	UCI
1	1 Isch.heart dis.	1,056	133.4	112.0	92.3	134.7
2	2 Cerebrovasc.dis	504	63.7	53.1	39.8	69.3
3	3 Trach/Bronch/lung Cancer	361	45.6	40.9	29.3	55.4
4	4 Hypten.heart dis.	233	29.4	25.7	16.8	37.7
5	5 Low.Respir.Infec.	248	31.3	25.5	16.6	37.4
6	6 COPD	226	28.5	24.4	15.7	36.3
7	7 Alzheimer/oth.demen.dis.	234	29.6	23.0	14.6	34.5
8	8 HIV/AIDS	178	22.5	19.6	12.2	29.8
9	9 Diabetes	143	18.1	15.7	8.9	25.5
10	10 Colon/rect.cancer	136	17.2	15.1	8.5	24.9
11	11 Breast Cancer	110	13.9	12.4	6.6	21.4
12	12 Self-inflict.Injur.	101	12.8	11.2	5.8	19.7
13	13 Liver Cancer	95	12.0	11.0	5.5	19.7
14	14 Lymphoma/Mult.myel.	93	11.7	10.4	5.1	18.9
15	15 Pancreas Cancer	92	11.6	10.3	5.0	18.8

Data sources: Ca. Dept. of Health Services, death master statistical file; Ca. Dept. of Finance, population projections

Deaths are San Francisco resident deaths. Rates are per 100,000 population.

Age adjusted rates are age-adjusted to standard US 2000 pop.

B. Obesity And Diabetes Are Responsible for Soaring Health Care Costs

17. Obesity and diabetes are generating extraordinary financial costs in the United States and in San Francisco. Between 1987 and 2001, rising obesity rates and obesity related illnesses accounted for more than one-quarter of the growth in health care spending in the United States.²¹ A 2002 study by the American Diabetes Association estimates that direct and indirect costs of diabetes were \$132 billion, which means that one out of every ten health care dollars spent in the U.S. is spent on diabetes and its complications.²² These sums are far larger if other obesity-related diseases and lost productivity are taken into account. Health care spending among people who are obese has been estimated to be 37% higher than among those with normal weight, and increases in the proportion of

²¹ Thorpe KE, Florence CS, Howard DH, Joski P. The Impact of Obesity on Rising Medical Spending. Health Affairs (Millwood) 2004 Jul-Dec; Suppl Web Exclusives:W4-480-6.

²² American Diabetes Assn., Economic Costs of Diabetes in the U.S. in 2002, *Diabetes Care* 23:3 (March 2003).

1 and spending on obese people relative to people of normal weight accounted for 27% of the rise in
2 inflation-adjusted per capita health care spending between 1987 and 2001.²³

3 18. Diabetes also costs state and local governments huge sums. The Juvenile Diabetes
4 Research Foundation International estimated that diabetes cost California alone about \$20.4 billion in
5 2004 in direct and indirect costs. In 2005, San Francisco General Hospital spent approximately \$25
6 million treating patients who presented with diabetes as their primary condition.

7 19. According to the California Department of Health Services, the obesity epidemic cost
8 the private and public sectors in California an estimated \$28 *billion* in direct medical expenses,
9 workers' compensation, and lost productivity in 2005.²⁴ In San Francisco, the epidemic costs an
10 estimated \$192 million a year in medical expenses, lost productivity and workers' compensation. In
11 fact, the Department alone spends an estimated \$15.5 million a year treating obesity-related
12 conditions.

13 **THE OBESITY EPIDEMIC IS CAUSED BY EXCESS CALORIC CONSUMPTION**

14 20. Experts agree that the extraordinarily rapid population-level weight gain that has
15 occurred over the past three decades is a result of our changing diet, rather than genetics. The food
16 industry in the U.S. encourages over-consumption of calories through increasingly large portions of
17 foods and beverages that are energy-dense, easily available, and inexpensive.²⁵

18 21. While increasing weight results from an imbalance between calories consumed
19 (nutrition) and energy expended (physical activity), it is clear that "rising obesity is primarily the
20

21
22
23 ²³ Thorpe KE, Florence CS, Howard DH, Joski P. The Impact of Obesity on Rising Medical
24 Spending. Health Affairs (Millwood). 2004 Jul-Dec; Suppl Web Exclusives:W4-480-6.

25 ²⁴ CAL. DEP'T OF HEALTH SERVS., THE ECONOMIC COSTS OF PHYSICAL INACTIVITY, OBESITY,
26 AND OVERWEIGHT IN CALIFORNIA ADULTS: HEALTH CARE, WORKERS' COMPENSATION, AND LOST
PRODUCTIVITY (2005),
<http://www.dhs.ca.gov/cdic/cpns/press/downloads/costofObesityToplineReport.pdf>.

27 ²⁵ Hill JO, Wyatt HR, Reed GW, Peters JC, Obesity and the Environment: Where Do We Go
28 from Here?, *Science* 2003; 299 (5608):853-5.

1 result of consuming more calories."²⁶ Unburned calories are stored as fat, regardless of whether the
2 calories come from fats, carbohydrates or proteins.²⁷

3 22. For this reason, calories are recognized as the most important element of nutrition
4 information needed to address the obesity epidemic. Contrary to McDonald's claim that "[e]mphasis
5 on calorie intake . . . may not contribute towards the maintenance of a healthy body weight," *see*
6 DeMuth Dec. ¶ 8, the FDA and other nutrition experts agree that "calorie information is *most* relevant
7 to obesity prevention."²⁸ FDA's Obesity Working Group concluded in 2004, "a focus on total calories
8 is *the most useful single piece of information* in relation to managing weight."²⁹

9 23. Even modest reductions in calorie intake can dramatically improve health. A
10 reduction of 300 calories twice per week (the difference between a large diet and a sugar-sweetened
11 soda) could result in a weight loss of more than 8 pounds in a year. This is equivalent to the weight
12 loss documented in a landmark study which found that progression to diabetes from pre-diabetes was
13 reduced by 58% in people who underwent moderate weight loss and modest increases in physical
14 activity.³⁰

15 24. Ordinance 40-08 aims to increase awareness of calorie intake by making calorie
16 information available on menu boards. It also requires three additional pieces of information on
17 menus: saturated fat, carbohydrates, and sodium. Contrary to the many claims in the declarations
18 submitted in support of CRA's motion and to the arguments in CRA's Memorandum of Points and
19

20 ²⁶ Bleich S, Cutler D, Murray C, Adams A. Why is the developed world obese? NBER
Working Paper # 12954; 2007, <http://www.nber.org/papers/w12954>.

21 ²⁷ When calorie consumption decreases, for example through a reduction in portion size,
22 reduction in other unhealthy nutrients, such as saturated fat or sodium, also frequently occur, as
evidenced by the chains own published information for varying portion sizes. *See* McDonald's
Nutrition Facts, http://www.mcdonalds.com/app_controller.nutrition.index1.html.

23 ²⁸ The Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight
24 Gain and Obesity, Final Report (May 2006) ("Keystone Report"), at 80 (emphasis added), Pl.
Appendix F.

25 ²⁹ U.S. FOOD AND DRUG ADMINISTRATION (FDA), CALORIES COUNT: REPORT OF THE
26 WORKING GROUP ON OBESITY (2004), at Part V(B) <http://www.cfsan.fda.gov/~dms/owg-toc.html>
("FDA Calories Count Report") (emphasis added).

27 ³⁰ Diabetes Prevention Program Research Group. Reduction in the Incidence of Type 2
28 Diabetes with Lifestyle Intervention or Metformin. *Journal of Medicine* 2002; 346: 393-403.

Authorities, restaurants are *in no way prevented* by San Francisco's Menu Labeling Ordinance from providing additional nutrient information to their customers on menu boards. Ordinance 40-08 sets a floor for the nutritional information chain restaurants must provide, not a ceiling.

THE RISE IN OBESITY HAS COINCIDED WITH AN INCREASE IN EATING AWAY FROM HOME

A. Americans Are Consuming An Increasing Portion Of Their Calories From Restaurant Food

25. The rise in obesity rates in the United States has coincided with the increased consumption of away-from-home foods. Eating out, and eating extra calories while eating out, contributes disproportionately to the excess calorie intake that fuels the obesity epidemic.³¹

26. Whereas in 1970 Americans spent just 26% of their food budget on food prepared away from home, they now spend almost half (46%) of their food dollars on such items. In 1994-1996, the average American consumed about one third of their calories from foods prepared outside of the home, up from 18% less than 20 years earlier.³²

27. The increasing number of chain restaurants, which serve food that is easily available, inexpensive and high in calories, has facilitated this trend. Between 2005 and 2009, the number of fast food establishments is projected to increase from 266,300 to 287,437 establishments.³³ Of the approximately 4,500 restaurants in San Francisco, an estimated 372, or 12%, are chain restaurants that are subject to the requirements of Ordinance 40-08.

28. Fast food has become a staple of the American diet. An estimated 30% of children between the age of four and nineteen eat fast food on a typical day.³⁴ On average, children and youth

³¹ St-Onge MP, Keller KL, Heymsfield SB. Changes in childhood food consumption patterns: a cause for concern in light of increasing body weights. *American Journal of Clinical Nutrition* 2003; 78:1068-1073; French SA, Harnack L, Jeffery RW. Fast food restaurant use among women in the Pound of Prevention study: dietary, behavioral and demographic correlates. *International Journal of Obesity* 2000; 24:1353-1359.

³² Guthrie JF. et al. Role of Food Prepared Away from Home in the American Diet, 1977-78 Versus 1994-96: Changes and Consequences. *Society for Nutrition Education* 2002; 34:140-150.

³³ C. Barnes & Co. 2008 Barnes Reports: U.S. Fast Foods Restaurants Industry (NAICS 72221). 2007.

³⁴ Bowman, S.A., Gortmaker, S.L., Ebbeling, C.B., Pereira, M.A., Ludwig, D.S. 2004. Effects of fast food consumption on energy intake and diet quality among children in a National Household (continued on next page)

aged 11-18 visit fast food outlets twice per week.³⁵ In addition, 37% of adults report eating in fast food establishments.³⁶

B. Away-From-Home Meals Such As Those Served At Chain Restaurants Have Larger Portions, More Calories, And Lower Nutritional Value Than Meals Prepared At Home

29. Studies have documented patterns of increasing portion sizes, particularly at fast-chain restaurants, since the 1970s, in a pattern that parallels the epidemic of obesity.³⁷ On average, portion sizes and calories increased for soft drinks by 49 calories, for French fries by 68 calories, and for hamburgers by 97 calories per serving.³⁸ Because even small changes, such as eating just 10 more calories per day over the course of a year, can result in weight gain of one pound, the potential impact of increases in portion size ranging from 50 to 100 calories is dramatic.

30. Meals eaten away from home are associated with increased calorie intake. Despite Dr. Allison's allegation that the "evidence submitted in favor of the unique role of restaurants as contributing to the obesity epidemic is strictly observational, and more importantly, equivocal," the

(footnote continued from previous page)

Survey. *Journal of Pediatrics*. 113(1): 112-118., <http://pediatrics.aappublications.org/cgi/reprint/113/1/112>.

³⁵ UNIV. OF CAL., AGRIC. & NATURAL RES., NUTRITION ONLINE MEDIA KIT, FACT SHEET, <http://news.ucanr.org/mediakits/nutrition/nutritionfactsheet.shtml> (citing *Inst. of Med., Preventing Childhood Obesity: Health in the Balance* (2005)).

³⁶ Paeratakul S, Ferdinand D, Champagne C, Ryan D, Bray G. Fast-Food Consumption Among U.S. Adults and Children: Dietary and Nutrient Intake Profile, *Journal of the American Dietetic Association*. 103: 1332-1338 (2003).

³⁷ Nielsen, S. J., and B. M. Popkin. Patterns and trends in food portion sizes, 1977-1998. *Journal of the American Medical Association*. 2003; 289(4):450-453; Young, L. R. and M. Nestle. The Contribution of Expanding Portion Sizes to the US Obesity Epidemic. *American Journal of Public Health* 2002; 92(2):246-249; Guthrie, J. F., B. H. Lin, and E. Frazao. Role of food prepared away from home in the American diet, 1977-78 versus 1994-96: Changes and consequences. *Journal of Nutrition Education and Behavior* 2002; Ello-Martin, J. A., J. H. Ledikwe, and B. J. Rolls. The Influence of Food Portion Size and Energy Density on Energy Intake: Implications for Weight Management. *The American Journal of Clinical Nutrition* 2005; 82(1 Suppl.):236S-241S. 34(3):140-150; Young L.R. and Nestle M. Portion Sizes and Obesity: Responses of Fast-Food Companies. *Journal of Public Health Policy* 2007; 28: 238-248.

³⁸ Nielsen, S. J., and B. M. Popkin. Patterns and trends in food portion sizes, 1977-1998. *Journal of the American Medical Association*. 2003; 289(4):450-453.

1 evidence that restaurant and fast food are the fastest growing component of the national increase in
2 caloric intake is incontrovertible.

3 31. The nationwide Food Consumption Survey revealed that energy (calorie) intake from
4 restaurant/fast food as a percentage of total energy intake doubled (+90%) between 1977 and 1996, as
5 national caloric intake increased for Americans by nearly 200 calories per day, from 1,791 to 1,983
6 calories. Restaurants and fast food were the fastest growing source of calories in this period, while
7 calories from food at home fell.³⁹ Indeed, the report by the FDA-commissioned Keystone Forum on
8 Away-From-Home Foods ("Keystone Report") observed that "[e]ating out more frequently is
9 associated with obesity, higher body fatness, and higher body mass index."⁴⁰ Children eat almost
10 twice (1.8 times) as many calories when eating out than when eating at home.⁴¹

11 32. Numerous studies show that people who eat at fast food establishments consume more
12 calories. A 1994-1996 survey of 17,370 adults and children found that adults who ate at fast food
13 restaurants consumed 205 more calories per day than those who did not, and children ate 155 more
14 calories.⁴² In a survey of more than 9,000 adults, mean caloric intake on days when fast food was
15 consumed was 206 calories higher than on other days.⁴³ This increase in calories would result in a
16 three-pound weight gain each year if a consumer were to eat fast food only once each week.
17 Similarly, in a study of nearly 900 women, increased frequency of eating at fast food restaurants was
18

19 ³⁹ Nielsen SJ, Siega-Riz AM, Popkin BM. Trends in energy intake in the United States
20 between 1977-1996: Similar shifts seen across all age groups. *Obesity Research* 10:370-378 (2002)

21 ⁴⁰ Keystone Report (Pl. Appendix F), at 27; see also Kant, AK & Graubard, BI. Eating out in
22 America, 1987-2000: Trends and Nutritional Correlates. *Preventive Medicine* 2004;38:243-249
(Analysis of data from the 1987 and 1992 National Health Interview Surveys (NHIS) and the 1999-
2000 National Health and Nutrition Examination Survey (NHANES) found that the number of meals
eaten out was associated with eating more calories, total fat and saturated fat. Eating out also was
associated with higher BMIs in women.)

23 ⁴¹ Zoumas-Morse C, Rock C, Sobo E, Neuhouser M. Children's patterns of macronutrient
24 intake and associations with restaurants and home eating. *Journal of the American Dietetic
Association* 2001; 101(8):923-925.

25 ⁴² Paeratakul S, Perdinand D, Champagne C, Ryan D, Bray G. Fast-food consumption among
26 US adults and children: dietary and nutrient intake profile. *Journal of American Dietetic Association*
2003; 103(10):1332-1338.

27 ⁴³ Bowman S, Vinyard B. Fast food consumption of US adults: impact on energy and nutrient
28 intakes and overweight status. *Journal of the American College of Nutrition* 2004; 23(2):163-168.

1 associated with higher total calorie intake.⁴⁴ This association has also been shown among adolescents
 2 and children. A study of 4,746 students age 11-18 years found that regular fast food consumption
 3 was associated with 800 extra calories per week in boys and 660 extra calories per week in girls.⁴⁵
 4 Such calorie excess could translate into a weight gain of 10 pounds or more per year. An increase of
 5 129 calories per day among high- versus low-frequency consumers of fast food was also reported in a
 6 large national cohort of adolescent girls.⁴⁶

7 33. Fast food consumption translates into an increase in body weight in both adults and
 8 children.⁴⁷ In a study of more than 9,000 adults, eating fast food increased the prevalence of
 9

10 ⁴⁴ French SA, Harnack L, Jeffery RW. Fast food restaurant use among women in the Pound
 11 of Prevention study: dietary, behavioral and demographic correlates. *International Journal of*
 12 *Obesity* 2000; 24:1353-1359 see also Kruger, J et al. Dietary Practices, Dining Out Behavior and
 13 Physical Activity Correlates of Weight Loss Maintenance. *Preventing Chronic Disease: Public*
 14 *Health Research, Practice, and Policy* 2008;5:1-14 (A survey of adults found that people who did not
 15 eat at fast-food restaurants were more successful at maintaining their weight loss than people who ate
 16 at fast-food restaurants two or more times a week).

17 ⁴⁵ French SA, Story M, Neumark-Sztainer D, Fulkerson JA & Hannan P. Fast food restaurant
 18 use among adolescents: associations with nutrient intake, food choices and behavioral and
 19 psychosocial variables. *International Journal of Obesity*, 2001; 25: 1823-33.

20 ⁴⁶ Schmidt M, Affenito SG, Striega-Moore R, Khoury PR, Barton B, Crawford P, Kronsberg
 21 S, Schreiber G, Obarzanek E, Daniels S. Fast-food intake and diet quality in black and white girls:
 22 the National Heart, Lung, and Blood Institute Growth and Health Study. *Archives of Pediatrics &*
 23 *Adolescent Medicine* 2005; 159(7):626-631.

24 ⁴⁷ Duffey KJ, Gordon-Larsen P, Jacobs DR, Williams OD & Popkin BM. Differential
 25 associations of fast food and restaurant food consumption with 3-y change in body mass index: the
 26 Coronary Artery Risk Development in Young Adults Study. *American Journal of Clinical Nutrition*
 27 2007; 85:201-208; French SA, Harnack L, Jeffery RW. Fast food restaurant use among women in the
 28 Pound of Prevention study: dietary, behavioral and demographic correlates. *International Journal of*
 29 *Obesity* 2000; 24:1353-1359; Niemeier H, Raynor H, Lloyd-Richardson E, Rogers M, Wing R. Fast
 30 food consumption and breakfast skipping: predictors of weight gain from adolescence to adulthood in
 31 a nationally representative sample. *Journal of Adolescent Health* 2006; 39:842-849; Pereira MA,
 32 Kartashov AI, Ebberling CB, VanHorn L, Slattery ML, Jacobs DR & Ludwig DS. Fast-food habits,
 33 weight gain, and insulin resistance (the CARDIA study): 15-year prospective analysis. *Lancet* 2005;
 34 Thompson OM, Ballew C, Resnicow K, Must A, Bandini LG, Cyr H, Dietz WH. Food purchased
 35 away from home as a predictor of change in BMI z-score among girls. *International Journal of*
 36 *Obesity* 2004; 28:282-289.365:36-42; Satia JA, Galanko JA, Siega-Riz AM, Eating at fast food
 37 restaurants is associated with dietary intake, demographic, psychosocial and behavioral and
 38 behavioral factors among African Americans in North Carolina. *Public Health Nutrition*: 7(8), 1089-
 39 1096; Guthrie JF. et al. Role of Food Prepared Away from Home in the American Diet, 1977-78
 40 Versus 1994-96: Changes and Consequences. *Journal of Nutrition Education and Behavior*. 2002;
 41 34(3):140-150; Binkley, UK, Eales J, Jekanowski M, The relation between dietary change and rising
 42 US obesity. *International Journal of Obesity* (2000) 24, 1032-1039.

1 overweight by 27-31%.⁴⁸ Among 3,394 adults in the Coronary Artery Risk Development in Young
 2 Adults Study (CARDIA), eating fast food was positively associated with a higher Body Mass Index
 3 (BMI), a key measure of obesity. This same association has been found in different contexts, such as
 4 among Mexican children in San Diego, where 4-7-year-old children were twice as likely to be obese
 5 if they ate in fast food restaurants,⁴⁹ and among Minnesota secondary school students.⁵⁰ Follow-up
 6 studies further strengthen the evidence for a causal association between eating fast food and weight
 7 gain. In a study of 3,031 adults (part of CARDIA) who were followed up for 15 years, baseline fast
 8 food intake was directly associated with increases in body weight.⁵¹ Similarly, in a study of almost
 9 10,000 adolescents, more days of fast food consumption at baseline predicted increases in BMI at
 10 five-year follow-up.⁵² In a cross-sectional study of boys and girls in three age groups, those aged 12-
 11 19 years who consumed foods away from home were more likely to have a higher BMI percentile.⁵³

12 34. Sit-down chains also serve food associated with increased caloric intake and weight
 13 gain. One study compared food selections made by adolescents who were asked to order a dinner
 14 meal from both sit-down chain restaurants and fast food restaurants. Meals selected at Chili's,
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 16
 17

18 ⁴⁸ Bowman S, Vinyard B. Fast food consumption of US adults: impact on energy and nutrient
 19 intakes and overweight status. *Journal of the American College of Nutrition* 2004; 23(2):163-168

20 ⁴⁹ Duerksen SC, Elder JP, Arredondo EM, Ayala GX, Slymen DJ, Campbell NR, Baquero B.
 21 Family restaurant choices are associated with child and adult overweight status in Mexican-American
 22 families. *Journal of the American Dietetic Association* 2007; 107(5): 849-853.

23 ⁵⁰ French SA, Story M, Neumark-Sztainer D, Fulkerson JA & Hannan P. Fast food restaurant
 24 use among adolescents: associations with nutrient intake, food choices and behavioral and
 25 psychosocial variables. *International Journal of Obesity*, 2001; 25: 1823-33.

26 ⁵¹ Pereira MA, Kartashov AI, Ebberling CB, VanHorn L, Slattery ML, Jacobs DR & Ludwig
 27 DS. Fast-food habits, weight gain, and insulin resistance (the CARDIA study): 15-year prospective
 28 analysis. *Lancet* 2005; 365:36-42

⁵² Niemeier H, Raynor H, Lloyd-Richardson E, Rogers M, Wing R. Fast food consumption
 and breakfast skipping: predictors of weight gain from adolescence to adulthood in a nationally
 representative sample. *Journal of Adolescent Health* 2006; 39:842-849.

⁵³ Huang TT, Howarth NC, Lin BH, Roberts SB & McCrory MA. Energy intake and meal
 portions: associations with BMI percentile in US Children. *Obesity Research* 2004; 12 (11): 1875-
 1885

1 Denny's and Outback Steakhouse had even higher calorie content than at comparison restaurants
2 McDonald's and Taco Bell.⁵⁴

3 35. Evidence also shows that eating meals away from home is associated with having a
4 poor diet. The United States Department of Agriculture has observed that away-from-home foods
5 have lower nutritional quality than home foods.⁵⁵ Eating fast food is associated with lower fruit and
6 vegetable consumption and greater consumption of sweetened beverages.⁵⁶ Generally, individuals
7 who eat fast foods consume more calories and have poorer diet quality than those who do not.⁵⁷

8 **CONSUMERS CONSISTENTLY UNDERESTIMATE THE NUMBER OF CALORIES, FAT,
9 CARBOHYDRATES, AND SODIUM CONTAINED IN RESTAURANT MEALS**

10 36. While Americans are eating out more than ever before and restaurant foods tend to
11 have higher calorie counts than home-cooked meals, consumers consistently underestimate the
12 number of calories in menu items.⁵⁸ As the FDA-commissioned Keystone Report concluded,

13 ⁵⁴ Yamamoto JA, Yamamoto JB, Yamamoto BE, Yamamoto LG. Adolescent calorie/fat menu
14 ordering at fast food restaurants compared to other restaurants. *Hawaii Medical Journal*. 2006
15 Aug;65(8):231-6

16 ⁵⁵ See Lin B, et al., Away-From-Home Foods Increasingly Important to Quality of American
17 Diet. U.S. Dep't of Agric., Econ. Research Serv., *Agriculture Info. Bull.* No. 749 (1999),
18 <http://www.ers.usda.gov/publications/aib749/aib749.pdf>.

19 ⁵⁶ Taveras EM, Berkey CS, Rifas-Shiman SL, et al., Association of Consumption of Fried
20 Food Away from Home with Body Mass Index and Diet Quality in Older Children and Adolescents,
21 *Pediatrics*, Oct. 2005; 116(4): e518-524; Crawford, D et al. Which Food-related Behaviors Are
22 Associated with Healthier Intakes of Fruits and Vegetables among Women?. *Public Health Nutrition*
23 2007;10:256-265 (A cross-sectional survey found that Australian women who ate meals from fast-
24 food restaurants were less likely to eat two or more servings of vegetables and two or more servings
25 of fruit a day.);

26 ⁵⁷ See Bowman, S.A., Gortmaker, S.L., Ebbeling, C.B., Pereira, M.A., Ludwig, D.S. 2004.
27 Effects of fast food consumption on energy intake and diet quality among children in a National
28 Household Survey. *Journal of Pediatrics*. 113(1): 112-118,
<http://pediatrics.aappublications.org/cgi/reprint/113/1/112>. (concluding that children who ate fast
food consumed more calories per gram of food and had poorer diet quality); Paeratakul S, Ferdinand
D, Champagne C, Ryan D, Bray G. Fast-Food Consumption Among U.S. Adults and Children:
Dietary and Nutrient Intake Profile, *J. of the Am. Dietetic Ass'n* 103: 1332-1338 (2003) (concluding
that adults who reported eating fast foods had higher intakes of calories and fat, and lower intakes of
vitamins A and C than adults who did not eat fast food); M. Schmidt, et al., Fast-Food Intake and Diet
Quality in Black and White Girls, *Archives Of Pediatric And Adolescent Medicine*. 159: 626-631
(2004) (concluding that fast food intake in girls between the ages of 9 and 19 was associated with
increased calorie and fat consumption).

⁵⁸ Burton S, Creyer EH. What consumers don't know can hurt them: Consumer evaluations
and disease risk perceptions of restaurant menu items. *The Journal of Consumer Affairs*. 2004;
38(1):121-145.

1 "[w]ithout nutrition information, consumers typically are unable to assess the caloric content of
2 foods."⁵⁹ Although federally mandated nutrition labeling on food products for sale in supermarkets
3 facilitates informed choice for meals eaten at home, consumers lack such essential information when
4 eating in restaurants. This information gap constitutes a significant barrier to healthy food choices.⁶⁰

5 37. A recent study found that calories in restaurant items were almost *two times* more than
6 what consumers expected.⁶¹ A March 2007 poll conducted in California found that an overwhelming
7 number of Californians are unable to identify fast food and restaurant menu items with the
8 fewest/most calories, salt, or fat.⁶² Moreover, steadily increasing portion sizes in restaurant meals
9 make consumers even more likely to underestimate nutritional content.⁶³

10 38. Even experienced nutrition professionals have difficulty accurately estimating the
11 calorie content of restaurant food. In one study, while these professionals could accurately describe
12 the calories in a cup of milk, they generally underestimated calories in restaurant food by 200 to 600
13 calories. For example, dietitians estimated on average that a typical hamburger with onion rings meal
14 had 865 calories when it actually had 1,550. Given that even experienced professionals in the field of
15 nutrition cannot accurately estimate the calorie content of restaurant foods, consumers are even less
16 likely to do so.⁶⁴

17
18 ⁵⁹ Keystone Report (Pl. Appendix F), at 68, 73.

19 ⁶⁰ U.S. Food and Drug Administration (FDA) and Center for Food Safety and Applied
20 Nutrition (CFSAN). Counting Calories: Report of the Working Group on Obesity," 2004.
<http://www.cfsan.fda.gov/~dms/owg-toc.html>.

21 ⁶¹ Burton S, Creyer EH, Kees J, Huggins K. Attacking the obesity epidemic: the potential
22 health benefits of providing nutrition information in restaurants. *American Journal of Public Health*.
2006; 96:1669-1675.

23 ⁶² CAL. CTR. FOR PUB. HEALTH ADVOCACY, Statewide poll of 523 registered California voters
24 conducted on March 20-31, 2007 by Field Research Corp.,
www.publichealthadvocacy.org/menulabelingpoll.html.

25 ⁶³ See Young LR, Nestle M. Expanding Portion Sizes in the U.S. Marketplace: Implications
26 for Nutrition Counseling, *Journal of the American Dietetic Association*. 103: 231, 231-34 (2003);
Brian Wansink, Pierre Chandon P, Meal Size, Not Body Size, Explains Errors in Estimating Calorie
Content of Meals, *Annals of Internal Medicine*. 145: 326, 326-32 (2006).

27 ⁶⁴ J. Backstrand, et al., *Fat Chance* (Washington, DC: Center for Science in the Public Interest,
28 1997).

39. It is difficult for consumers to be able to discern that a far lower calorie option is often available within a group of similar products. For example, calories in cheeseburgers at Burger King vary more than three-fold:

Cheeseburger	330 calories
Whopper Junior with cheese	410 calories
Double Whopper with cheese	990 calories
Triple Whopper with cheese	1,230 calories

A consumer ordering a salad at Burger King with the goal of eating food with fewer calories might be startled to learn that dressing can have more calories than the salad; and the calories can vary two-fold – from 300 to 670 – not counting the croutons:

BK Tendergrill Chicken Garden Salad	240 calories
BK Tendercrisp Chicken Garden salad	400 calories
Ken's Fat Free Ranch Dressing	60 calories
Kens' Honey Mustard Dressing	270 calories

And that calories in McDonald's desserts can vary more than ten-fold:

McDonald's shakes	420-1160 calories
McDonald's hot fudge sundae	330 calories
Fruit and yogurt parfait with granola	160 calories
Vanilla low fat ice cream cone	150 calories
Apple dippers w/ low fat caramel dip	105 calories

**EVIDENCE SHOWS THAT, WHEN GIVEN NUTRITIONAL INFORMATION,
CONSUMER USE THAT INFORMATION TO MAKE LOWER CALORIE AND
HEALTHIER CHOICES**

40. Both common sense and published scientific evidence demonstrate why making nutrition information readily available at the point of purchase will influence many consumers to make lower-calorie, healthier choices.⁶⁵ Since 1994, the federal Nutrition Labeling and Education Act (NLEA) has made nutrition information available to consumers on packaged foods purchased in retail stores. This information is widely used, with three quarters of American adults reporting that

⁶⁵ Burton S, Creyer EH, Kees J, Huggins K. Attacking the obesity epidemic: the potential health benefits of providing nutrition information in restaurants. *American Journal of Public Health*. 2006; 96:1669-1675.

1 they examine food labels.⁶⁶ The calorie section is the most frequently consulted part of the Nutrition
 2 Facts panel on packaged foods, with 73% of consumers reporting that they look at calorie content.⁶⁷
 3 Nearly half (48%) of those who consult the nutrition information on packaged foods report changing
 4 their food purchasing habits as a result of reviewing this information.⁶⁸

5 41. Similarly, consumers are interested in knowing the calorie content of restaurant foods
 6 and will use it to make more informed choices. Six nationally representative polls have found that
 7 anywhere from 62% to 87% of Americans support requiring restaurants to list nutrition information.⁶⁹
 8 In studies where calorie information is provided, consumers choose high-calorie items 24% to 37%
 9 less often.⁷⁰ A 2005 study found that providing nutrition information at the point of sale in campus
 10 dining facilities had a positive influence on the food purchasing behavior of college students.⁷¹
 11 Similarly, another study found that signs showing the calorie content of available foods in a cafeteria
 12 setting significantly decrease the number of calories that people purchase.⁷²

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 14
 15 ⁶⁶ US Department of Health and Human Services (US DHHS), Centers for Disease Control
 and Prevention, National Center for Health Statistics. Healthy People 2000 Final Review. 2001.

16 ⁶⁷ International Food Information Council (IFIC) Foundation. Food & Health Survey:
 Consumer Attitudes Toward Food, Nutrition & Health. Washington, DC: 2007.

17 ⁶⁸ Levy AS, Derby BM. The Impact of NLEA on Consumers: Recent Findings from FDA's
 18 Food Label and Nutrition Tracking System. Washington DC: Center for Food Safety and Applied
 Nutrition. Food and Drug Administration. 1996.

19 ⁶⁹ Center for Science in the Public Interest. Anyone's Guess: The need for nutrition labeling at
 20 fast-food and other chain restaurants. Washington, DC: Center for Science in the Public Interest,
 2003; Harvard Forums on Health. Obesity as a Public Health Issue: A Look at Solutions. National
 Poll by Lake, Snell, Perry & Associates. June 2003.

21 ⁷⁰ Burton S, Creyer EH, Kees J, Huggins K. Attacking the obesity epidemic: the potential
 22 health benefits of providing nutrition information in restaurants. *American Journal of Public Health*.
 23 2006; 96:1669-1675. Once again, the DeMuth (McDonald's) declaration does not accurately reflect
 an authority it cites. Describing the Burton study, she states, "Purchase intent for the more-healthy
 24 items was increased only when both calorie plus nutrient information were provided." DeMuth Dec.
 ¶ 13. Actually, the authors concluded that while calorie information with additional nutritional
 information affected more choices, calorie information alone had a significant effect on certain
 25 consumer purchase intentions.

26 ⁷¹ Conklin MT, Cranage DA, Lambert CU. College students' use of point of selection nutrition
 information, *Topics in Clinical Nutrition*. 2:20, 97, 97-108 (2005).

27 ⁷² Milich R, Anderson J, Mills M. Effects of visual presentation of caloric values on food
 28 buying by normal and obese persons, *Perceptual & Motor Skills*. 1976 Feb;42(1):155-62.

42. Most recently, Los Angeles County published a study quantifying the potential impact of mandatory menu labeling at fast food and large chain restaurants. Using a conservative assumption that calorie postings would result in 10% of large chain restaurant patrons ordering reduced calorie meals, with an average reduction of 100 calories per meal, Los Angeles concluded that menu labeling would avert 39% of the 6.75 million pound average annual weight gain in the county population. The Los Angeles study is attached hereto as Exhibit B.

43. CRA questions the usefulness of nutritional information if consumers are unaware of their recommended daily calorie intake. Such knowledge, however, is not essential for nutrition labeling to be effective. As noted in the FDA's Keystone Report: "The data collected since the NLEA was implemented in 1994 suggest that people tend to use food label information to compare "like" products, rather than to make selections across product lines."⁷³ Nutritional information provided in restaurants allows consumers to compare meal options and make better selections irrespective of whether they know their daily-recommended intake. For example, a consumer will be able to choose between a small portion of McDonalds fries knowing that it has 250 calories versus a large portion at fries at 570 calories, between its Deluxe Breakfast with syrup at 1,410 calories instead of the Big Breakfast with a regular sized biscuit at 720 calories, or between a large Coke at 310 calories versus a small one for 150 calories or a diet Coke for <1 calorie. Also, CRA ignores that Ordinance 40-08 requires restaurants to include the following statement on menus in a clear and conspicuous manner: "Recommended limits for a 2,000 calorie daily diet are 20 grams of saturated fat and 2,300 milligrams of sodium." See Health Code Section 468.3(b)(2). Thus, Ordinance 40-08 educates consumers about recommended daily allowances so that they can make more informed choices.

44. The argument advanced in the Declaration of Michael Andres (McDonald's) that requiring posting by some and not all restaurants will create a competitive disadvantage for affected restaurants is purely speculative, as is the allegation that these restaurants will lose business. In fact, it is entirely plausible that consumers, who are increasingly choosing foods based on nutritional value or perceptions of healthfulness, will prefer purchasing at restaurants where nutrition information is

⁷³ Keystone Report (Pl. Appendix F), at 72.

1 available. The proposal to require nutrition labeling had widespread support before the Board of
2 Supervisors, and a 2007 study by the California Center for Public Health Advocacy found 84% of
3 respondents support "requiring fast-food and chain restaurants to post nutrition information on their
4 menus."⁷⁴ Given the public support for menu labeling, the availability of nutrition information to
5 consumers may in fact come to be seen as a competitive advantage despite CRA's dire predictions.

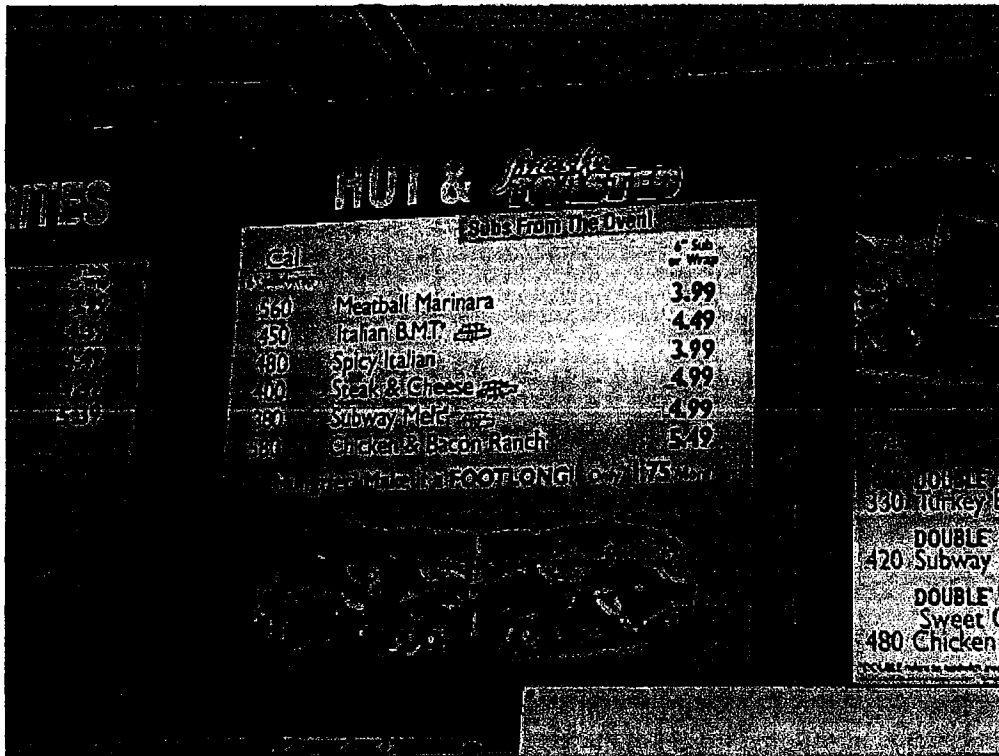
6 45. Contrary to the Andres Declaration (McDonald's), which speculates that San
7 Francisco's Menu Labeling Ordinance could cause revenue loss, consumer confusion, and delays in
8 lines, Subway Restaurants has reported no such difficulties since they began posting calorie
9 information on their menu boards in New York City. As part of a Centers for Disease Control and
10 Prevention educational webcast, John Musco, Development Agent for Subway restaurant's Greater
11 New York Region, said this about the calorie posting measure: "We've seen no negative feedback, no
12 loss of sales in our stores because of it. It's been positive."⁷⁵ Subway's experience demonstrates that
13 restaurants can provide nutritional information while still offering clear, attractive and uncluttered
14 menu boards.

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24 ⁷⁴ Cal. Ctr. for Pub. Health Advocacy, Menu Labeling Poll: Californians Overwhelmingly
Support Mandatory Menu Labeling, <http://www.publichealthadvocacy.org/menulabelingpoll.html>.

25 ⁷⁵ Centers for Disease Control and Prevention and University of North Carolina at Chapel Hill
26 School of Public Health. Cutting-Edge Legal Preparedness for Chronic Disease Prevention. Public
Health Grand Rounds [webcast]. November 29, 2007.
27 http://www.publichealthgrandrounds.unc.edu/legal/webcast_hi.htm.

Subway Menu Boards in Place in Manhattan on July 2, 2007⁷⁶



NUTRITION DISCLOSURES IN RESTAURANTS WILL LIKELY LEAD TO THE DEVELOPMENT OF HEALTHIER MENU OFFERINGS

46. In addition to informing consumers, the Department anticipates that requiring nutritional disclosures will motivate the food service industry to improve its menu offerings. According to the FDA-sponsored Keystone Report:

A key benefit of mandatory nutrition labeling on packaged foods has been the reformulation of existing products and the introduction of new, nutritionally improved products. Between 1991 (before the implementation of the NLEA) and 1995 (after implementation) the number of fat-modified cheeses has tripled, and market share for fat-modified cookies increased from zero percent of the market to 15%. In a similar fashion, nutrition labeling on menus and menu boards will likely spur nutritional improvements in restaurant foods.⁷⁷

⁷⁶ Photograph provided by the New York City Department of Health & Mental Hygiene.

⁷⁷ Keystone Report (Pl. Appendix F), at 73.

CURRENT NUTRITION INFORMATION PRACTICES AT CHAIN RESTAURANTS ARE INADEQUATE

47. The current practices of chain restaurants do not effectively transmit nutrition information to consumers. At least 50% of chain restaurants do not make any nutritional information available to customers anywhere.⁷⁸ While CRA has submitted declarations from some that do, only a minuscule proportion of their customers see the nutritional information that is available.

A. Websites And Nutritional Hotlines Are Insufficient To Convey Nutritional Information To Customers

48. According to the declaration of Debra DeMuth, Director of Global Nutrition for McDonald's, McDonald's has over 50 million patrons per day, amounting to 18.3 billion visits per year, but received only 578,000 annual "hits" on their nutrition information website in 2007—presumably including search engine redirects and other spurious hits. Even if we attributed all website hits to customers, this would represent a rate of 0.003% hits per meal (or one hit for every 31,500 meals). Even including all off-site methods described by DeMuth for obtaining nutrition information (578,000 website visits, a projected 48,000 annual calls to the toll free hotline), the use of these sources remains minuscule compared to the number of meals served.

49. Similarly, Burger King's Fiscal 2007 Annual report states that ""Worldwide 11 million guests a day visit a BURGER KING restaurant."⁷⁹ Stephanie Quirantes' declaration notes that the Burger King website receives an average of 78,866 visits a month, while its interactive "Build a Meal" site receives approximately 46,479 visits each month. Further, the linked "Healthy Dining Finder" has received 83,102 hits since March 2007. Even when considering all of these as unique visits by customers (certainly an overestimate) and even assuming that all of the individuals who visit the Burger King website do so to access calorie or nutrition information (highly unlikely), there are *at most* approximately 1.57 million electronic inquiries for nutritional information. This is certainly a large number, but when compared to Burger King's some 4 billion customer visits each year, it

⁷⁸ Wootan MG, Osborn M. Availability of Nutrition Information from Chain Restaurants in the U.S., *American Journal of Preventative Medicine* 2006 vol. 30 at 266-268.

⁷⁹ See http://media.corporate-ir.net/media_files/irol/87/87140/2007_AR.pdf.

1 translates to approximately 0.039% of meals (or one in 2,500) served for which nutritional
2 information might have been obtained electronically.

3 **B. Few Consumers See The On-Site Information Currently Available At Some**
4 **Chain Restaurants**

5 50. The methods for providing onsite nutrition information described in the declarations of
6 DeMuth (McDonald's) and Quirantes (Burger King Corporation) – methods that they claim to be
7 more comprehensive than the requirements of San Francisco's Menu Labeling Ordinance – are also
8 not effective in transmitting nutrition information to consumers.

9 51. The New York City Department of Health and Mental Hygiene conducted a large exit
10 interview survey of 7,318 diners at a random sample of 275 of restaurants in May and June of 2007.
11 With the exception of Subway, only 4% of chain restaurant consumers reported seeing calorie
12 information.⁸⁰

13 52. Only at Subway, which posted some nutritional information near cash registers at the
14 time of New York's survey, did a substantial proportion – 31% – of consumers report seeing calorie
15 information.⁸¹ When chain restaurants post calories even more prominently, as required by San
16 Francisco's Menu Labeling Ordinance, consumers will be even more likely to see the nutritional
17 information and make healthier choices.

18 53. Provision of nutrition information in restaurants can have an impact even if not all
19 patrons make use of the information. The DeMuth declaration (McDonald's) cites Krukowski's
20 report⁸² that about 50% of students in a study said that they were not likely to use caloric information.
21 Yet, conversely about 50% of patrons in that same study stated that they *would* use nutrition
22 information if it were available, suggesting that calorie posting will have a substantial effect on public
23 health. National estimates suggest that affecting energy balance by even 100 calories per day could

24 ⁸⁰ Bassett M *et al.*, Purchasing Behavior and Calorie Information at Fast-Food Chains in New
25 York City, 2007. *American Journal of Public Health*. (Jun 12, 2008).

26 ⁸¹ *Id.*

27 ⁸² Krukowski RA, Harvey-Berino J, Kolodinsky J, Narsana RT, Desisto TP. Consumers may
28 not use or understand calorie labeling in restaurants. *Journal of the American Dietetic Association*
2006; 106(6):917-20.

1 alter the trajectory of the average weight gain that is driving the obesity epidemic.⁸³ Even the
 2 National Restaurant Association accepts this, stating, "Research shows that affecting energy balance
 3 by 100 calories per day could prevent weight gain in most of the population."⁸⁴

4 54. The key difference between restaurants' current voluntary practices and the disclosures
 5 required by Ordinance 40-08 is that nutrition information will be seen by most consumers under
 6 Ordinance 40-08, while it is seen by 4% of consumers (excluding Subway) using present methods.
 7 Unlike disclosures on food wrappers or tray liners, the disclosures mandated by Ordinance 40-08 will
 8 be seen at the point of sale, *before* consumers select their order. As the FDA-commissioned
 9 Keystone Report concluded, "information provided at the consumer's point of decision, wherever that
 10 might be, is most likely to be used and useful to the consumer."⁸⁵ The FDA Obesity Working
 11 Group's 2004 report similarly recommended that restaurants provide "readily available, nutrient
 12 content information *at the point-of-sale*."⁸⁶

13 55. Despite the initiatives described in the DeMuth (McDonald's) and Quirantes (Burger
 14 King) Declarations, nutrition information is invisible to the overwhelming majority of consumers
 15 who stand on line each day and order items from its menu boards. As described in the declarations
 16 submitted by CRA, chain restaurants do not typically display nutritional information where and when
 17 consumers make their choices and purchases. Such information is typically displayed only where it is
 18 hard to find, difficult to read, or accessible only after a purchase is made. Thus, the provided
 19 information has little or no impact on choice.

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 23 ⁸³ Hill JO, Wyatt HR, Reed GW, Peters JC. Obesity and the environment: where do we go
 24 from here? *Science* 2003; 299(5608):853-5.

25 ⁸⁴ Garren DM, Gay J. Comment; Notice of Intention to Repeal and Reenact 81.50 to Article
 26 81 of the New York City Health Code; Mandatory Calorie Statements. National Restaurant
 Association. November 27, 2007 p.13.

27 ⁸⁵ Keystone Report (Pl. Appendix F), at 81.

28 ⁸⁶ *FDA Calories Count Report*, at Part V(B) (emphasis added).

**SCIENTIFIC EXPERTS RECOMMEND THAT NUTRITIONAL INFORMATION BE
READILY AVAILABLE IN RESTAURANTS, ESPECIALLY AT THE POINT OF
PURCHASE**

56. Although McDonald's claims that there is no "public health community consensus on menu board labeling," *see* DeMuth Dec. ¶ 12, nutritional labeling of restaurant foods has been recommended as a useful strategy for addressing obesity and its related illnesses by the:

- FDA
- U.S. Surgeon General
- National Academies' Institute of Medicine
- American Medical Association
- American Diabetes Association
- American Heart Association
- American Cancer Society
- American Academy of Pediatrics
- Center for Science in the Public Interest, and
- American Public Health Association.⁸⁷

The FDA's Working Group on Obesity has concluded that "the pervasiveness of the obesity epidemic means that more nutrition information *must* be presented to consumers in restaurant settings."⁸⁸

Similarly, the U.S. Surgeon General has called for "increasing availability of nutrition information for

⁸⁷ *See FDA Calories Count Report*, at Part V(B) (emphasis added); U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001), *available at* <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>; INSTITUTE OF MEDICINE, PREVENTING CHILDHOOD OBESITY: HEALTH IN THE BALANCE (Jeffrey P. Coplan et al. eds., 2004) (emphasis added); AM. MED. ASS'N, Press Release, AMA Adopts Policies to Promote Healthier Food Options to Fight Obesity in America (June 27, 2007), *available at* <http://www.ama-assn.org/ama/pub/category/17768.html>; AM. HEART ASS'N, Position Statement on Menu Labeling (March 4, 2008), *available at* <http://www.americanheart.org/downloadable/heart/1204661406112Policy%20Position%20Statement%20on%20Menu%20Labeling.pdf>; AM. PUBLIC HEALTH ASS'N, Support for Nutrition Labeling in Fast-Food and Other Chain Restaurants (Nov. 9, 2004), *available at* <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1300>; <http://www.nyc.gov/html/doh/downloads/pdf/public/notice-intention-hc-art81-50-1007.pdf>.

⁸⁸ *See FDA Calories Count Report*, Section V(B)(2) (emphasis added).

1 foods eaten and prepared away from home."⁸⁹ The National Academies' Institute of Medicine has
 2 recommended that: "Fast-food and full-service restaurants should expand healthier meal, food, and
 3 beverage food options (including children's meals) and provide calorie content and general nutrition
 4 information *at point of purchase*."⁹⁰ In a 2004 report, the Institute concluded that because "[t]he
 5 obesity epidemic is a serious public health problem that calls for *immediate* action to reduce its
 6 prevalence as well as its health and social consequences ... actions should be based on the best
 7 available evidence---as opposed to waiting for the best possible evidence."⁹¹ The 2006-2007 report of
 8 the President's Cancer Panel also recommends: "Make nutrition information on restaurant foods
 9 readily available on menus and understandable to consumers."⁹²

10 57. The final report of the FDA's Keystone report recommends that: "Away-from-home
 11 food establishments should provide consumers with calorie information in a standard format that is
 12 easy to use."⁹³ This was the *first* recommendation in Chapter 4 of the report. As the report noted
 13 when providing operational tips for accomplishing its recommendation:

14 Information should be provided in a manner that is easy for consumers to see and use as part
 15 of their purchasing and eating decisions. Consumer might view such information, for
 16 example, when standing at a counter, while reviewing a menu board, in a car when reading a
 17 drive-through menu, or when sitting down at a table reviewing a menu, a table tent, or others
 18 means of providing information.⁹⁴

19 CRA's Memorandum of Points and Authorities cites other parts of the report, such as the desirability
 20 of further research, but not this key recommendation.

21 ⁸⁹ U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO
 22 PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001), *available at*
 23 <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

24 ⁹⁰ Institute of Medicine of the National Academies. Industry can play a role in preventing
 25 childhood obesity. Fact Sheet 2004. Drawn from Preventing Childhood Obesity, Health in the
 26 Balance 2005, *available at* www.iom.edu.

27 ⁹¹ *Id.* (emphasis added).

28 ⁹² President's Cancer Panel. Promoting Healthy Lifestyles. Policy, Program and Personal and
 Recommendations for Reducing Cancer Risk. 2006-2007 Annual Report. U. S. Department of Health,
 National Institutes of Health, National Cancer Institute. Bethesda, Maryland, 2007.

⁹³ Keystone Report (Pl. Appendix F), at 76.

⁹⁴ *Id.* at 77-78.

1 58. In concluding that the best available scientific evidence supports the provision of
2 nutrition information at the point of purchase, San Francisco is part of a growing national consensus
3 that menu labeling legislation is likely to yield significant health and economic benefits by providing
4 consumers with the information they need to make better informed choices and decrease their risk for
5 obesity.

6 **CHAIN RESTAURANTS ARE AN APPROPRIATE FOCUS FOR NUTRITION**
7 **DISCLOSURE REQUIREMENTS**

8 59. Chain restaurants represent an appropriate focus for regulation for several reasons. As
9 outlined above, the vast majority of chain restaurants typically serve food that is clearly associated
10 with excess caloric intake and with obesity. In addition, children, an especially vulnerable segment
11 of the population, are targeted by chain restaurant marketing campaigns.

12 **A. Chain Restaurants Often Serve Standardized Meals That Are High In Calories**
13 **And Low In Nutritional Value**

14 60. As explained above in paragraphs 29-35, fast food and chain restaurants often serve
15 highly caloric meals and eating such meals is associated with being overweight or obese. Chain
16 restaurants also typically have standardized menus, recipes and preparation methods that allow for
17 accurate nutritional disclosures.

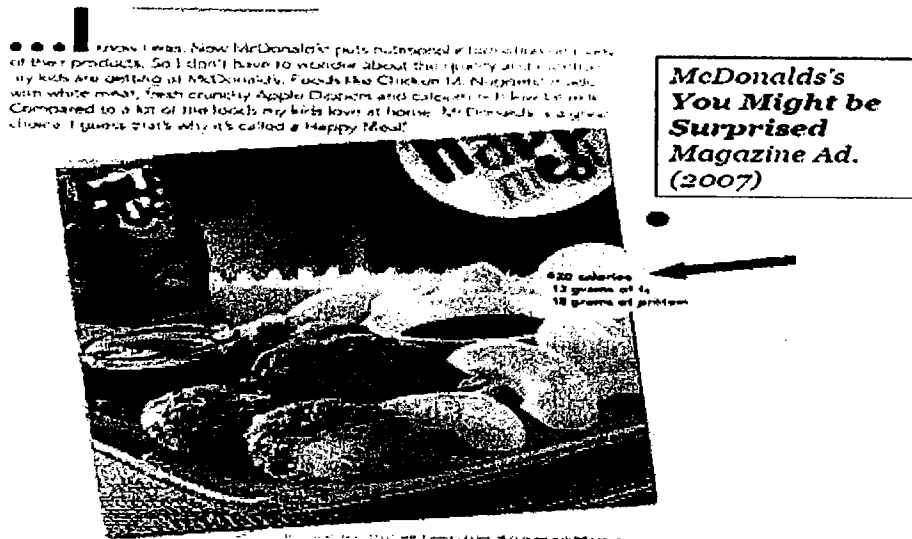
18 **B. Chain Restaurants Often Target Children In Their Advertisements**

19 61. Many of the chain restaurants covered by Ordinance 40-08 make extensive use of
20 advertising to promote the appeal and wholesome image of their products, particularly to susceptible
21 groups such as children. The major chains use marketing strategies directly aimed at children to
22 establish a preference for their fast food brand,⁹⁵ and children who view such television
23 advertisements are about 50% more likely to eat fast food.⁹⁶ Such advertising does not contain any

24 ⁹⁵ Connor, SM. Food-related advertising on preschool television: building brand recognition
25 in young viewers. *Pediatrics*. 118(4):1478-85, 2006

26 ⁹⁶ Taveras EM, Sandora TJ, Shih, M-C, Ross-Degnan D, Goldmann DA, Gillman M W. The
27 association of television and video viewing with fast food intake by preschool-age children. *Obesity*.
28 14(11):2034-41, 2006 Nov.

information about the risk of obesity for those consuming fast food regularly, and many such advertisements may inaccurately imply that fast food is generally wholesome, healthy food. Ads typically feature slender, healthy-looking children and parents. For instance, the ad below from McDonald's suggests that McDonald's is good place to obtain a meal for a child, a place where parents "don't have to worry about the quality or nutrition."



62. This ad deceptively suggests that parents do not have to worry about their children's nutrition at McDonald's. Based on the options listed on McDonald's website, however, the average number of calories in McDonald's Happy Meal offerings is approximately 530 calories, 26% higher than the advertised meal.⁹⁷ The average caloric content of a Happy Meal is over half of a 3-year-old's daily-recommended number of calories and about 40% of the recommended daily caloric intake for a child between four and eight years old.⁹⁸ Indeed, over 20% of the Happy Meals listed on McDonald's

⁹⁷ http://www.mcdonalds.com/app_controller.nutrition.categories.happymeals.index.html

⁹⁸ American Heart Association, *Table: Dietary Recommendations for Children*, available at <http://www.americanheart.org/presenter.jhtml?identifier=3033999>.

1 child between four and eight years old.⁹⁸ Indeed, over 20% of the Happy Meals listed on McDonald's
 2 website have over 600 calories, nearly half of the average recommended number of calories for 4 to 8
 3 year olds. Such calorie dense meals contrast sharply with McDonald's advertising which promises to
 4 provide "[a]ge appropriate portion sizes for our kids meals."⁹⁹

5 63. Researchers at Robert Wood Johnson Foundation's national research program
 6 *Bridging the Gap* found that fast-food advertisements make up the largest category of all food related
 7 advertisements seen by teens.¹⁰⁰ "Clearly our kids are getting bombarded with poor nutritional
 8 messages every day," said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert
 9 Wood Johnson Foundation.¹⁰¹ An National Institutes of Health-supported study looked at television
 10 fast-food advertising seen by children and estimated that these advertisements were responsible for
 11 18% of overweight in children ages 3-11 and 14% in adolescents.¹⁰² Given the epidemic of
 12 childhood obesity, Ordinance 40-08 is an important tool to help parents offset the effects of fast-food
 13 advertising on their children.

14 **ORDINANCE 40-08 REQUIRES NUTRITION DISCLOSURES – IT DOES NOT FORCE A**
 15 **MESSAGE**

16 64. CRA argues that Ordinance 40-08 forces restaurants to voice the City's points of view
 17 that "patrons *must* consider the caloric content of food when ordering in a restaurant," and "calories
 18 are the only nutritional criterion that patrons need to consider." Pl. Mem. at 23-24. Posting calorie
 19 information on menu boards will not force anyone to take calories into consideration, any more than

20 ⁹⁸ American Heart Association, *Table: Dietary Recommendations for Children*, available at
<http://www.americanheart.org/presenter.jhtml?identifier=3033999>.

21 ⁹⁹ McDonald's, *Fact Sheet: Communicating with Children*, available at
[http://www.mcdonalds.com/corp/about/factsheets.RowPar.0001.ContentPar.0001.ColumnPar.0005.Fi](http://www.mcdonalds.com/corp/about/factsheets.RowPar.0001.ContentPar.0001.ColumnPar.0005.File1.tmp/Communicating%20to%20Children%20FACT%20SHEET.pdf)
 22 [le1.tmp/Communicating%20to%20Children%20FACT%20SHEET.pdf](http://www.mcdonalds.com/corp/about/factsheets.RowPar.0001.ContentPar.0001.ColumnPar.0005.File1.tmp/Communicating%20to%20Children%20FACT%20SHEET.pdf).

23 ¹⁰⁰ Powell, LM, Szczypka G, Chaloupka, FJ, Braunschweig CL. Nutritional content of
 24 television food advertisements seen by children and adolescents in the United States. *Pediatrics*
 120:576-583, 2007.

25 ¹⁰¹ Robert Wood Johnson Foundation. New Study Confirms Vast Majority of Ads Seen by
 Kids Promote Foods High in Sugar, Fat or Sodium. Sep 4, 2007 - Chicago, Ill. Accessed February 6,
 2008 at <http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?productid=21922>

26 ¹⁰² Chou SY, Rashad I, Grossman M. Fast Food Advertising on television and its influence on
 27 childhood obesity. R01 DK54826 from the National Institute of Diabetes and Digestive and Kidney
 Diseases Report. December 2006.

1 having labels on clothing (which are mandatory) forces you to consider buying cotton rather than
 2 polyester, or access to the Nutrition Facts Panel forces you to consider buying tofu. The Ordinance
 3 simply requires that consumers have ready access to calorie information when making a choice. It
 4 does not in any way imply that calories are the only important nutritional criterion, especially since it
 5 requires that the amount of saturated fat, carbohydrates and sodium also be provided on menus for
 6 each menu item. It simply establishes a minimum requirement for disclosure of the information of
 7 the greatest public health importance in fighting the obesity epidemic.

8 **THE REQUIREMENTS OF ORDINANCE 40-08 ARE NARROWLY TAILORED AND ARE**
 9 **NECESSARY TO EFFECTIVELY COMMUNICATE WITH CONSUMERS**

10 65. In contrast to the virtual invisibility of nutritional information in many chain
 11 restaurants, menus and menu boards are effective means of providing information. Indeed, the
 12 evidence submitted by CRA describes how effectively menu boards can communicate information to
 13 their patrons. As Michael Andres of McDonald's explained in his declaration, "[o]ur menu boards are
 14 the focal point of our business inside our restaurants." Andres Dec. ¶ 2. Given the importance of
 15 menus and menu boards for communicating with customers, nutritional disclosures on menus and
 16 menu boards is essential to inform consumers about the nutritional content of foods and overcome the
 17 failure of current practices that transmit nutritional information to no more than a small fraction of
 18 customers.

19 **NATURAL INGREDIENTS, FRESH FOODS AND CALORIE POSTING ARE**
 20 **COMPATIBLE**

21 66. Contrary to assertions of the CRA, there is nothing incompatible about cooks using
 22 fresh, non-processed foods and San Francisco's Menu Labeling Ordinance. Mr. Randolph, from
 23 T.G.I. Friday's, states that their food is often cut, measured, and prepared by hand by individual
 24 cooks in its restaurants, introducing some variation. He also notes that there are some natural
 25 differences in the size and nutritional content of meats and other ingredients in T.G.I. Friday's meals.
 26 To address Mr. Randolph's concerns about inconsistency in natural ingredients, Ordinance 40-08
 27 provides that restaurants are only in violation of the Ordinance if they do not make disclosures in the
 28 form and location required by the Ordinance, the nutritional information disclosed is different from
 what the restaurant knows or believes to be the true and accurate information, or the nutritional

information "[d]eviates from what actual analysis or other reliable evidence shows to be the average content of a representative sample of the Menu Item by more than 20%." S.F. Health Code § 468.3(g)(2). Mr. Randolph does not explain why this 20% safe-harbor is insufficient to account for the natural variations in food and preparation methods. Chain restaurants employ processes and follow specifications to ensure consistency in the preparation of their menu items. As Mr. Randolph explains, T.G.I. Friday's chefs "follow specifications on how to prepare dishes, and they and other employees receive training on how to prepare and present our menu items." Randolph Dec. ¶ 8. Indeed, T.G.I. Friday's and most chain restaurants are already providing nutritional information on menus in New York even though that ordinance does not contain a 20% safe harbor provision. Thus, there can be no doubt that is feasible for T.G.I. Friday's and other chain restaurants to provide nutritional information on their menus.

STANDARD OF EVIDENCE FOR PUBLIC HEALTH DETERMINATIONS

67. The Allison declaration raises the question of what should be the standard of evidence for promulgating public policy. The standard for recommending certain biomedical interventions is generally the evidence of benefit from randomized, placebo-controlled clinical trials. The grading system which Allison cites is based on an "A" rating for strong evidence from randomized controlled trials in such settings. While such trials represent one of the strongest forms of scientific evidence, they are rarely available, or even feasible, for public policy interventions. For example, could we realistically or ethically randomize people and expose some to sunburn for decades to observe their skin cancer rates?

68. Had evidence from randomized controlled trials been the requirement for implementation of public health policies, we would have failed to implement many of the major public health triumphs on the past hundred years, including:

- Chlorination of water
- Fluoridation of water
- Elimination of lead-based paint
- Mandatory installation of automobile safety seat belts

- Smoke detectors
- Smoke-free air policies
- Standards to reduce hazardous conditions in the workplace

69. Adherence to a rigid standard of randomized controlled trials for social policy making would have cost millions of lives lost to diseases, motor vehicle accidents, fires, and cancer as well as resulting in millions more lead-poisoned and intellectually impaired children. Government has the obligation to create public policy wisely, based on the best available evidence, to protect the public's health, and cannot wait to act until all scientific questions are answered, especially when policies that protect the public's health are likely to carry no or minimal risks. As the FDA-sponsored Keystone Report:

The need for additional research should not preclude reasonable action. As noted in the Institute of Medicine's 2004 report, Preventing Childhood Obesity: Health in the Balance "[t]he obesity epidemic is a serious public health problem that calls for immediate action to reduce its prevalence as well as its health and social consequences. Therefore...actions should be based on the best available evidence—as opposed to waiting for the best possible evidence." With regard to this last consideration, the best available evidence for obesity prevention and control is grounded in a solid, well-documented knowledge base regarding energy balance. Keystone Forum participants believe that what is needed now is reasonable guidance and action to help make healthy food choices easier for individuals and families.¹⁰³

70. The Allison declaration also references Seymour et al, 2004.¹⁰⁴ Seymour makes clear that not only randomized clinical trials, but a variety of forms of evaluation of effectiveness of nutrition policies are relevant, many of which can only be performed post-implementation: "... policy interventions can be more difficult to evaluate than environmental interventions which may account for the lack of such studies in the literature ... The impact of this policy change may not come only from individual awareness, knowledge and behavior change but may also come from

¹⁰³ Keystone Report (Pl. Appendix F), at 20.

¹⁰⁴ Seymour JD, Yaroch AL, Serdula M, Blanck HM, Khan LK. Impact of nutrition environmental interventions on point-of-purchase behavior in public: a review. *Preventative Medicine* 2004; 39: S108-S136

1 changes to the foods served by the restaurant so the nutritional content of menu items pre- and post-
2 intervention should be compared."

3 **ORDINANCE 40-08 IS AN IMPORTANT PART OF SAN FRANCISCO'S BROADER**
4 **EFFORT TO REDUCE OVERWEIGHT AND OBESITY**

5 71. The Department does not propose that nutrition labeling *alone* can reverse the obesity
6 epidemic. Rather, the Menu Labeling Ordinance is one of a series of policy efforts being pursued in
7 San Francisco to improve education and empower consumers to make healthier choices. For
8 instance, San Francisco's Mayor has instituted a program called "Shape Up San Francisco" to
9 "increase the awareness of and opportunities for increased physical activity and improved nutrition
10 where people live, play, work and learn." Specifically, Shape Up San Francisco seeks to:

- 11 • Increase access to affordable, healthy food in neighborhoods with limited access.
- 12 • Complete the streets for improved walking and biking.
- 13 • Promote overall community aesthetics and atmosphere of safety to encourage outdoor
14 physical activity and recreation.
- 15 • Create a Physical Activity Council to coordinate physical activity services and policy work.
- 16 • Adopt and implement health and wellness worksite criteria/standards.
- 17 • Adopt standards for the provision of healthy, sustainable food at all meetings and events.
- 18 • Develop and adopt legislation requiring city funded youth programs to adhere to nutrition
19 standards.
- 20 • Create, adopt and implement policies to address physical activity in after school sites.
- 21 • Work with San Francisco healthcare facilities to create and implement health and wellness
22 policies to improve healthy eating and physical activity environments for staff, patients,
23 clients, and visitors.
- 24 • Increase reimbursement for obesity prevention and treatment by insurers.¹⁰⁵

25
26
27 ¹⁰⁵ See Shape Up San Francisco: About Us, available at
28 http://www.sfgov.org/site/shapeupsf_index.asp?id=58059.

72. Thus, the Department and the City are undertaking a broad range of measures to help residents of San Francisco prevent or reverse weight gain. The need for additional actions to halt the obesity epidemic is no reason to refrain from taking action on posting nutrition information.

ORDINANCE 40-08 IS NECESSARY TO AVOID CONSUMER CONFUSION OR DECEPTION

73. Ordinance 40-08 is necessary to prevent consumer confusion or deception concerning the nutritional content of the food they order at chain restaurants.

74. The different calorie counts for different menu items are not intuitively obvious to the average consumer. Indeed, consumers are often shocked to discover the calorie content in foods they thought were lower in calories. For instance, few people would guess that the pecan-crusted chicken salad at T.G.I. Friday's (1,360 calories) has more calories than the cheeseburger and fries (1,290 calories).¹⁰⁶ Or that a smoked turkey sandwich (930 calories) at Chili's has more calories than a sirloin steak (540 calories). Or that a large milk shake from McDonald's has over 1,000 calories, about half the total daily-recommended amount of calories.

75. Another source of consumer confusion or deception is that the calorie increase that comes with ordering a larger size of an item is often not reflected in the price differentials. For example, going from a McDonald's \$1.79 medium fries with 380 calories to a \$1.99 large fries with 570 calories is an 11% price increase but a 50% calorie increase. Calorie information will be particularly important to highlight these increases.

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¹⁰⁶ Roni Caryn Rabin, *New Yorkers Try To Swallow Calorie Sticker Shock*, MSNBC.COM (July 17, 2008), <http://www.msnbc.msn.com/id/25464987>.

76. Even when chain restaurants make nutritional information available, it is often confusing or deceptive. For instance, an "individual-sized" Chicago Classic pizza from Uno Chicago Grill ("Uno") has 115% of a person's daily-recommended intake of calories, nearly 250% of a person's daily fat allowance, and 186% of a person's daily sodium allowance.¹⁰⁷ Even though Uno's menu confirms that the "individual" pizza is meant to serve only one person,¹⁰⁸ in order to avoid having to disclose these shocking facts, Uno's website provides nutrition information for the "individual" pizza by "serving size," and the "individual" size pizza contains three servings for purposes of its nutritional disclosures.¹⁰⁹ Because Uno's website lists the caloric, fat and sodium content as only 1/3rd of the actual totals, a customer who checks the nutritional disclosures is likely to believe that the individual pizza has only 1/3rd of the calories, fat and sodium that it actually has, unless that customer happens to notice the deceptive serving size definition.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge.

Executed on July 31, 2008

By: 

MITCHELL H. KATZ, M.D.

¹⁰⁷ Nutrition Information for Chicago Classic Pizza, <http://www.unos.com/kiosk/nutritionUnos.html>.

¹⁰⁸ Menu from Uno Chicago Grill, http://641.unotogo.com/zgrid/proc/site/sitemnup.jsp?nls_sf=tm5216&nls_st=tm1270421&id=4103317810560&ctx=ct156772812&mnuid_it=61684&vnmi_it=174.

¹⁰⁹ Nutrition Information for Chicago Classic Pizza, <http://www.unos.com/kiosk/nutritionUnos.html>.



Center for Weight & Health

Center Information Sheet

Potential Impact of Menu Labeling of Fast Foods in California

For more information on the
Dr. Robert C. and Veronica Atkins Center for
Weight & Health, UC Berkeley
www.cnr.berkeley.edu/cwh
510-642-2915

SANDWICHES

HAMBURGER (300 cal)	1.29
DbL. BURGER w/ CHEESE (540 cal)	2.49
CRISPY CHICKEN SANDWICH (660 cal)	4.49
FISH FILET SANDWICH (380 cal)	2.29

SALADS

CAESAR SALAD W/ CHICKEN (550 cal)	4.29
RANCH SALAD w/ CHICKEN (580 cal)	5.29
ASIAN SALAD W/ CHICKEN (450 cal)	5.29
SIDE SALAD (140 cal)	1.29

SIDES

FRENCH FRIES (250 cal)	SMALL	1.29
FRENCH FRIES (380 cal)	MED	1.79
FRENCH FRIES (570 cal)	LG	2.29
CHICKEN NUGGETS (250 cal)	6 PCS.	2.29

SHAKES/DESSERTS

MILK SHAKE (420 cal)	12oz.	1.29
MILK SHAKE (580 cal)	16oz.	2.49
MILK SHAKE (1100 cal)	32oz.	1.29
ICE CREAM w/ CANDIES (710 cal)	16 oz.	2.00

California, like the rest of the nation, is experiencing an obesity epidemic. In California today, nearly 60% of Californians are either overweight or obese.¹ This epidemic did not occur overnight. Over the past decade Californians on average have gained about one pound per year.²

In the midst of the obesity epidemic, Americans now eat one billion meals a week outside the home.³ Restaurant dining has become more frequent in California and across the nation, among people of all incomes, ethnic and racial backgrounds. In 2006, Americans spent almost half (48 percent) of their food dollars on foods prepared outside the home, in comparison to 26 percent in 1970.⁴ The largest single source of food consumed away from home is fast food.⁵ In California alone there are an estimated 15,000 fast food establishments, nearly four times as many

EXHIBIT C

as there are grocery stores in the state.⁶ Given these trends, it is not surprising that adults now consume three times the calories from fast food than did their parents just two decades earlier.⁷




Fast food restaurants are more likely to be found in low-income neighborhoods and near low-income schools. Poorer neighborhoods have greater access to fast food and less access to supermarkets.^{8,9} In a new California study, nearly two-thirds of schools (65 percent) had a fast food restaurant within 1/6 of a mile of campus. Schools in low-income neighborhoods had even more fast food restaurants nearby than schools in higher income areas.¹⁰

According to a recent national survey, over one quarter (26.5 percent) of adults eat fast food on any given day, consuming **approximately 200 calories more on days when fast food is eaten.**¹¹ In a 2007 consumer survey of Californians 16-64 years of age, 82% of California adults in the five largest market areas in California – Fresno, Los Angeles, Sacramento, San Diego, and San Francisco – made fast food purchases at least once per month. These fast food consumers made fast food purchases an average of 14.9 times per month, the equivalent of 3.4 times per week.¹²

Estimating the caloric content of foods is difficult for consumers

Research shows that **consumers routinely underestimate the calories in food.**^{13,14,15,16,17} Even nutrition professionals underestimate the calories contained in meals typically available at fast food restaurants – by 200 to 600 calories.¹⁸ One reason it is challenging to estimate the calories in fast food, is that there is a wide range of calories contained in very similar products. For example, one popular fast food restaurant offers six similarly sized chicken sandwiches (from 8 ounces to 9 ounces) with a range of calories from 420 to 630 calories (Table 1), depending on whether they are grilled or fried, or have added bacon and other added ingredients. Based on this example, providing helpful information to consumers could allow consumers to save up to 210 calories, while still eating a similar product.

Table 1. Variation in Calorie Content of Similarly Sized Chicken Sandwiches at a Fast Food Restaurant ²⁰

Item		Serving Size (in ounces)	Calories
Grilled Regular Chicken Sandwich		8	420
Grilled Chicken BLT Sandwich		8.3	470
Breaded Regular Chicken Sandwich		8.1	530
Breaded Chicken BLT Sandwich		8.5	580
Breaded Chicken Club Sandwich		9	630

Small differences in calories of food selections can add up quickly given the large number of fast food visits in California. For example, a savings of approximately 3,100 calories in a month could be achieved if on each of 3.4 weekly visits, the average adult fast food consumer selects a grilled chicken sandwich instead of breaded chicken club sandwich. Similarly, two hamburger sandwiches of virtually the same serving size (a difference of 0.3 oz) at the same fast food restaurant differ by 80 calories, which could total to a savings of ~1,200 calories over a month, with an average of 3.4 weekly visits.

Similar items can differ greatly in size – even at the same chain. In addition to differences in preparation and added ingredients, menu items can differ greatly by portion size. Information about portion sizes of items is typically not specified or visible at point of purchase. **Table 2** lists the calorie content and portion sizes of different burgers found in quick serve restaurants. Without either portion size or calorie information on menu boards, a consumer would find it difficult if not impossible to accurately estimate the calorie content of menu items.

Even when nutrition information is provided, it is often not readily accessible. In a 2006 study of a major fast food chain in Washington, DC, it was necessary to ask two or more employees in order to obtain nutrition information in 62 percent of the outlets sampled.¹⁹ No outlet displayed information on menu boards where it could be readily seen when placing an order. Of the 59 percent of outlets that did provide in-store nutrition information for the majority of menu items, the most common venue used was the back of

tray liners (43 percent) typically distributed after food is received, and pamphlets (43 percent). The other 14 percent used other means such as on-site posters.

Table 2. Variation in Calorie Content of Fast Food Burgers of Different Size²⁰

Item	Serving Size (in ounces)	Calories
Regular Burger	3.5	250
Regular Cheeseburger	4	300
Large Burger	6	410
Extra Cheese Burger	5.8	440
Large Cheeseburger	7	510
Extra Large Burger	7.5	540
Extra Large Cheeseburger	9.8	740

People use nutrition information to help them make decisions about what to eat

Nutrition labeling of packaged foods has been mandated by the FDA since the 1990s. Nearly three out of four American adults use nutrition information on food labels of packaged foods, including calorie information.^{21,22} **Almost one half (48 percent) of American adults report that reading the nutrition information on food labels helped them change their purchasing habits.**²³

Basic nutrition information is helpful for healthy menu planning both at home and in restaurants. **Two-thirds of Americans in representative public opinion polls said they support requiring restaurants to list nutrition information.**^{24,25} **In California, 84% of a representative sample of adults support requiring fast-food and chain restaurants to post nutritional information on menus and menu boards.**²⁶ Menu labeling is also supported by leading health organizations and consumers across the nation.²⁷

Typically in fast food restaurants consumers rarely see or obtain nutrition information. In a recent study of over 7,000 patrons of 11 large fast food chains in New York City, only 4% of patrons saw calorie information when ordering food, even though it was available in brochures placed at condiment tables, on posters hung on a restaurant wall, or posted on the Internet.²⁸

Menu Board		
Item	Calories	Price
SANDWICHES		
HAMBURGER	280 Cal.	.89
CHEESEBURGER	330 Cal.	.99
DOUBLE CHEESEBURGER	470 Cal.	1.89
FRIED CHICKEN SANDWICH	550 Cal.	2.89
GRILLED CHICKEN SANDWICH	450 Cal.	2.89
SIDES		
FRIES (lg.)	540 Cal.	1.65
FRIES (sm.)	210 Cal.	1.05
ONION RINGS	900 Cal.	1.95
DRINKS		
CHOCOLATE SHAKE	770 Cal.	2.35
COLA (lg.)	330 Cal.	1.35
DIET COLA (lg.)	0 Cal.	1.35

Potential benefits of menu labeling in California

Changing consumer behavior to prevent weight gain

A 2008 study conducted at a fast food chain restaurant found that 32% of customers reported seeing calorie information posted on the splash guard (in front of ingredients used to make sandwiches) and that they purchased meals averaging 52 fewer calories than customers who did not see the calorie information. Among customers who said they used the calorie information, their meals averaged 99 calories lower than those who reported not using it.²⁸

Virtuous cycle – product reformulation to reduce calories

Calorie labeling at fast food chains could start a "virtuous cycle."²⁹ Restaurants may begin to introduce lower calorie items and smaller portion sizes so that consumers will have a greater variety of lower calorie choices. Based on experiences with the Nutrition Labeling Act for packaged foods, and recent legislation to include trans fatty acids on labels, companies were shown to be able to change formulation in ways that promote health and also maintain product appeal.²⁸

In response to consumer health concerns and legislative action such as the trans fatty acid bans, fast food companies have already begun to reduce the use of hydrogenated oils.³⁰ Similarly, a new law in New York City requiring calorie labeling on menus has resulted in some restaurants making beneficial changes to their offerings.³¹ Possible reformulations include changing ingredients (including condiments), changing cooking methods, and reducing portion sizes of menu items.

*Using calorie information at fast food restaurants
can help Californians to avoid gaining
millions of pounds*

To help illustrate a range of possible outcomes from menu labeling, **Table 3** provides a variety of scenarios based on different possibilities about the percentage of people who frequent fast food restaurants and notice calorie information. For all scenarios, the decrease in calories purchased is held at 52 calories per visit based on the impact measured in the New York City study described above.²⁸ Smaller reductions in daily calorie intake and resultant weight could occur if compensatory increases in intake were to occur at other times of day. However, greater reductions in calories and weight would likely be seen with product reformulation and portion size changes. *If 80% of adult customers notice calorie information on menu boards in California, and reduce calories in their purchases by 52 calories per visit, for example, this could result in an average annual weight gain avoided of 2.1 pounds per adult who frequents fast food restaurants.*

Table 3. Spectrum of Potential Impact of Calorie Labeling on Average Weight of Adults Who Frequent Fast Food Restaurants in California in Relation to Percentage of Patrons who Observe Calorie Information*

Scenario	Patrons observing calorie information (%)	Projected average weight change for adults who frequent fast food restaurants† (pounds/person)
No patrons see menu board labels	0	0.0
Few patrons see menu board labels‡	4	-0.1
Minority of patrons see menu board labels §	32	-0.9
Majority of patrons see menu board labels	80	-2.1
All patrons see menu board labels	100	-2.7

* Based on 3.4 visits/week by the 82% of California residents that visit a fast food restaurant on a given month - assuming situation continues for 1 year from Reference 12.

† Using value of 52 calorie reduction/visit for patrons observing calorie information from Reference 28. Based on a reduction of 3500 calories to prevent 1 pound of weight gain from Reference 33.

‡ Equivalent to percentage of customers at chain restaurants noticing calorie information from posters and brochures from Reference 28.

§ Equivalent to documented customer awareness of nutritional information posted on a splash guard from Reference 28.

Table 4 illustrates potential weight changes based on frequency of fast food visits for individuals who observe and respond to calorie menu labeling in a similar fashion to the New York Study (i.e., decrease consumption by an uncompensated 52 calories per visit). For example, for an individual who eats fast food 3.4 times per week (the average for 82% of California adults), an estimated 2.7 pounds per year less weight would be expected if calories labels are in place compared to if menus are not labeled. For an individual who eats fast food 7 times per week, the corresponding annual weight savings is 5.4 pounds.

Table 4. Spectrum of Potential Impact of Calorie Labeling on Average Weight of an Adult in Relation to Frequency of Fast Food Visits[†]

Fast Food Visits (times/week)	Projected average annual weight change for an adult who frequents fast food restaurants [†] (pounds/person)
1	-0.8
2	-1.5
3.4	-2.7
7	-5.4

[†]Using 52 calorie reduction/visit for patrons observing calorie information from Reference 28 and value of 3500 calories to prevent 1 pound of weight gain from Reference 33.

As **Figure 1** illustrates, the hypothetical scenarios presented to estimate changes in fast food customers can also be analyzed taking into account the entire population of the state of California. For example, if 80% of fast food customers observed posted calorie labeling then a total of approximately 40 million pounds of weight gain per year could be prevented among all adults in the state. If all of fast food customers observed the calorie labeling then an estimated 50 million pounds of weight gain would be prevented.

Figure 1. Spectrum of Potential Impact of Calorie Labeling on Weight of Entire Adult Population in California (Based on

estimation of 52 calorie reduction per purchase²⁸ and the current California adult population³²)

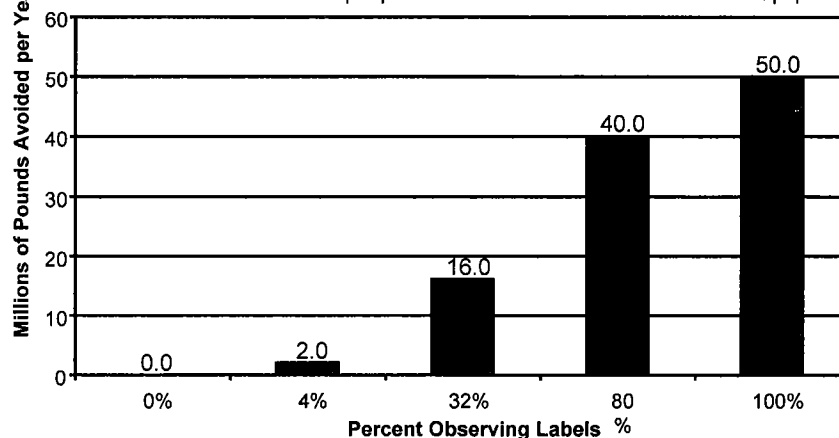
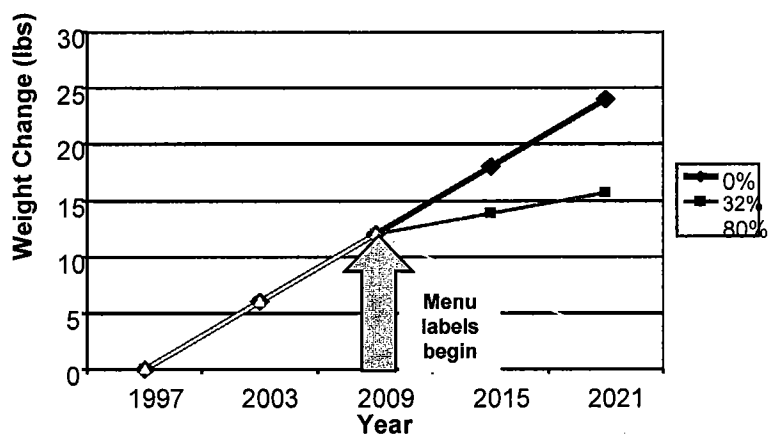


Figure 2 models the impact of different menu labeling scenarios on weight gain in Californian adults over time. The blue line represents the projection of continuing trends without any changes in caloric intake.² The red line represents the projection of changes made if menu labels were in place, and 32% of fast food customers in California noticed this information and changed their purchases to consume 52 fewer calories per visit. The green line models the impact of 80% of fast food customer making this change. Obviously the higher the number of people able to see calorie information and make even modest changes. The higher the potential to impact obesity rates. If a sizeable proportion of fast food customers were to see calorie information and make a modest change in caloric intake as a result, this choice could have a dramatic impact on weight gain for the state.

Figure 2. Weight Change of Average California Adult Since 1997 Based on Several Menu Labeling Scenarios
(Actual 1997-2003 and projected through 2021)



Conclusion: Menu Labeling Provides an Opportunity to Change the Course of the Obesity Epidemic in California

Posting calories on menus and menu boards would provide visible, easy-to-locate information to consumers. For an individual fast food consumer, responding to calorie content on menu boards at every fast food visit could translate into a decrease of over two pounds of weight per year (Table 5). If 80% of Californians see calorie menu labels at fast food chains, and make changes similar to those documented in the literature, this could result, on a population level, in an annual weight loss of nearly one pound per person per year for Californians -- compared to the current average weight gain of about one pound per year (Table 6). Menu board labeling thus has the potential to dramatically reverse the trajectory of the obesity epidemic in California.

Table 5. Estimated impact on an individual fast food consumer who sees calorie content posted on menu boards on all fast food visits

Description	Number	Data Source
a) Fast food visits per person who regularly eats at fast food restaurants	14.9 Visits per month	Reference 12
b) Months	12 per year	
c) Change (decrease) in calories purchased	-52 Calories per visit	Reference 28
d) Caloric equivalent of body weight	3500 Calories per pound	Reference 33
e) Estimated average weight change for adult fast food customers who see calorie information on menu boards	- 2.7 Pounds per year	$\frac{(a) \times (b) \times (c)}{(d)}$

Table 6. Possible statewide impact of posting calorie content on fast food menu boards

Description	Number	Data Source
a) Estimated average weight change for adult fast food customers who see calorie information on menu boards	- 2.7 Pounds per year	From Table 6 (e)
b) Estimated average weight change for all fast food customers (if estimating that 80% of fast food customers see calorie information on menu boards)	- 2.1 Pounds per year for all fast food customers	(a) x 80%
c) Estimated average weight change for all California adults (if 80% notice menu labels and 82% of Californians age 16-64 years regularly eat at fast food restaurants)	- 1.7 Pounds per year for all California adults	(b) x 82%
d) Average weight change for California adults <u>prior</u> to menu labeling	+1.0 Pounds per person per year	Reference 2
e) Estimated average weight change for California adults <u>after</u> menu labeling	- 0.7 Pounds per person per year	(c) + (d)
f) Estimated total weight change for 23 million California adults	- 40 million pounds annually	(e) x 23 million from Reference 32

Qualifications: This Information Sheet was created using the best available published evidence, which to date is limited. We recognize that there are differences in methodology and population samples among studies, and caution must be taken when generalizing to the larger population. Therefore this paper provides a variety of scenarios for discussion, using conservative estimates of consumer behavior change and a full spectrum of possibilities on the percentage of customers noticing calorie information. Weight estimations were based on Behavioral Risk Factor Surveillance data for 1999-2003 for adults, 18 years of age and over. California's population estimate was based on adults 18-64 years of age for the year 2006. Potential compensatory increases in intake were not included in scenarios. Possible impact of product reformulation was also not included in scenarios.

Prepared by: Dr. Robert C. and Veronica Atkins
Center for Weight and Health, UC Berkeley
in cooperation with the
California Center for Public Health Advocacy

For more information, visit www.cnr.berkeley.edu/cwh
and www.publichealthadvocacy.org

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Menu Labeling: One Way to Support Americans' Efforts to Eat Well and Watch their Weight



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PUBLIC INTEREST

*The nonprofit publisher of
Nutrition Action Healthletter*



Margo G. Wootan, D.Sc.
Director, Nutrition Policy

www.cspinet.org/nutritionpolicy

EXHIBIT D

Restaurant foods

Appetizers

	<u>Calories</u>	<u>Sat + Trans Fat (g)</u>
Buffalo Wings (12) w/ Dressing	1,010	22
Stuffed Potato Skins (8)	1,120	40
Cheese Fries (4 c) w/ Dressing	3,010	91

Entrees

French Toast w/ Syrup & Margarine	910	13
Caesar Salad w/Chicken	1,010	13
Spaghetti with Meatballs	1,160	10
Fresh Chicken and Broccoli Pasta	2,060	128 (total fat)

Meals

Chicken Ranch Sandwich & Fries	1,580	16
BK Double Whopper w/ Cheese	1,980	42
King Size Value Meal	2,170	39
Fried Seafood Platter		

Sweets

Cinnabon (1)	730	14
Fudge Brownie Sundae	1,130	30
Cheesecake Factory Carrot Cake (1 s)	1,560	23

Eating out linked to obesity



http://www.keystone.org/spp/documents/Forum_Report_FINAL_5-30-06.pdf

Portion sizes



Soft Drinks

7-Eleven

Double Gulp

8 cups (64 oz.)

600 calories

Can

1 1/2 c. (12 oz.)

140 calories

Official

serving

1 cup (8 oz.)

100 calories



Steak House serving
(Porterhouse)

About 1.25 lb.,
cooked (20 oz.)

1,100 calories

Dinner House
serving (Sirloin)

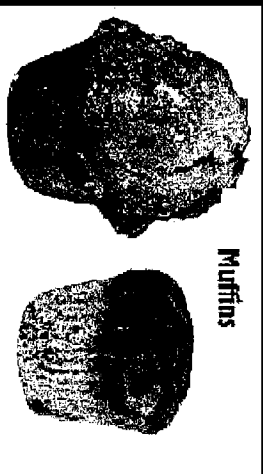
About 1/2 lb.,
cooked (7 oz.)

410 calories

Official
serving
(Sirloin)

About 1/5 lb.,
cooked (3 oz.)

220 calories



Muffins

Restaurant serving

1/4 lb. (4 oz.)

430 calories

Official serving

1/8 lb. (2 oz.)

190 calories

Which entrée on the children's menu at Chili's has the most calories?

- a. Corn dog
- b. Grilled cheese sandwich
- c. Chicken tenders (crispers)
- d. Ribs basket

Which entrée on the children's menu at Chili's has the most calories?

- a. Corn dog - 250 cal
- b. Grilled cheese sandwich - 420 cal
- c. *Chicken tenders - 590 cal*
- d. Ribs basket - 370 cal

**Which item at Dunkin' Donuts
has the fewest calories?**

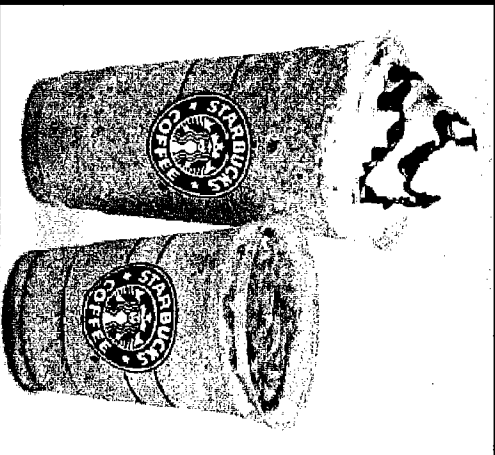
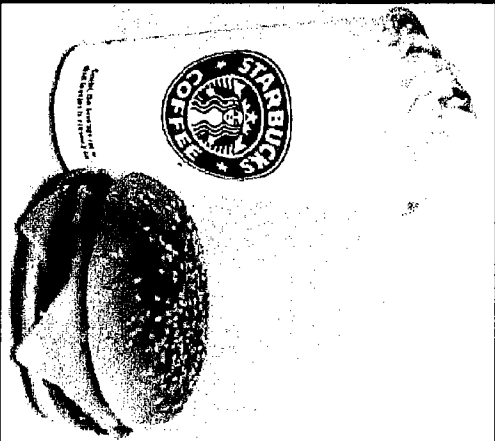
- a. Sesame bagel with cream cheese
- b. 2 jelly filled donuts
- c. Banana walnut muffin
- d. A medium (24 oz.) strawberry
banana smoothie

2 Jelly filled Dunkin' Donuts have the fewest calories

- a. Sesame bagel with cream cheese - 570 cal
- b. 2 jelly filled donuts - 420 cal
- c. Banana walnut muffin - 540 cal
- d. A medium (24 oz.) strawberry banana smoothie - 550 cal

Nutritional Quality of Restaurant Foods Vary Widely

<u>Starbucks, grande</u>	<u>Calories</u>	<u>Sat Fat (g)</u>
White Chocolate Mocha, whole & whip	500	14
Cappuccino, nonfat	80	0
Vanilla Latte, whole	280	6
Skinny Caramel Latte	130	0
Caramel Frappuccino, whip	380	9
Light Caramel Frappuccino	160	0



Bagels with cream cheese (baked on paninis day)				4.39 - 6.20	1.99
plain / Emmentaler cheese / cheddar / Swiss / Monterey Jack / pepperoni / sausage / ham / spinach / mushrooms / chicken / turkey / beef / veggie				MAKE IT A SALAD	3.19
cream cheese / plain / 1/2 cup (1/2 cup)				or less	4.19
Baked Omelette Sandwiches				Varies	8.49
Baked Omelette Sandwiches				Varies	2.89
or any bagel with your choice of 2 toppings: Swiss / mozzarella / cheddar / ham / spinach / turkey / chicken / roasted red peppers				MAKE IT A SALAD	3.59
additional toppings: 1.50				or less	4.99
Yogurt Parfait				Calories	Price
4.26	5.81	2.99	* Fruit Salad	216	2.69
Così Break Bar	4.63	2.19	Orange Juice	137	1.99
Kids Menu					
SANDWICHES SERVED WITH COSÌ CHIPS OR BABY CARROTS					
Turkey Sandwich	2.89	4.39	Shirley Temple	240	1.49
Tuna Sandwich	3.33	4.39	Milk	192	1.69
Cheese Pizza	7.69	6.59	Chocolate Milk	260	1.99
Pepperoni Pizza	9.11	7.19	Hot Chocolate	436	2.99
Goody Grilled Cheese	3.57	3.69	S'mores	751	7.79
Peanut Butter & Jelly	5.60	3.79			

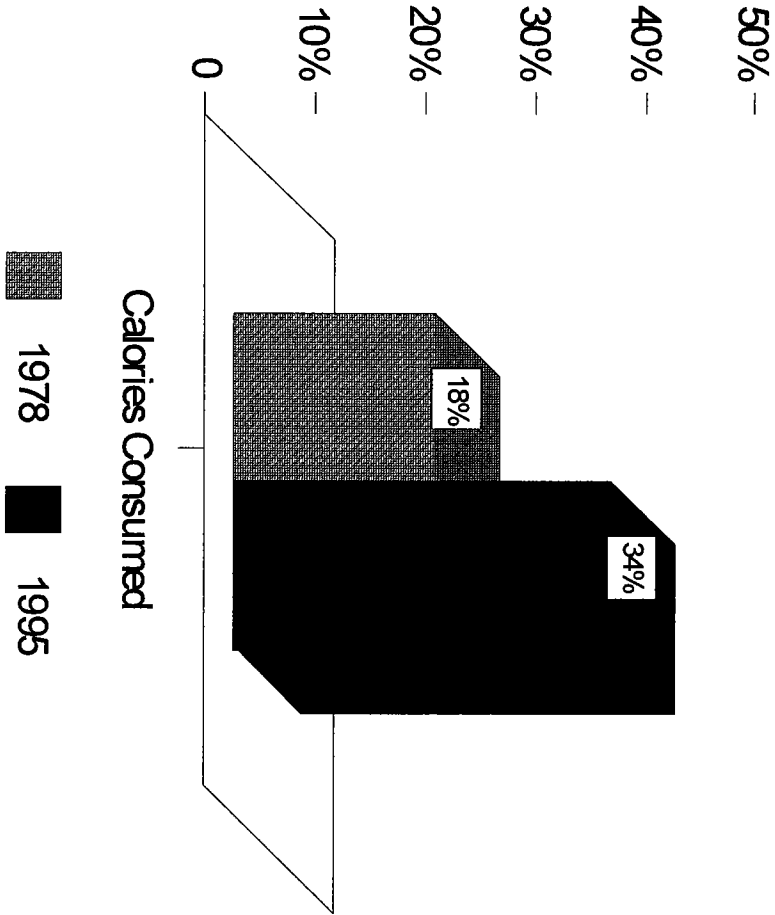
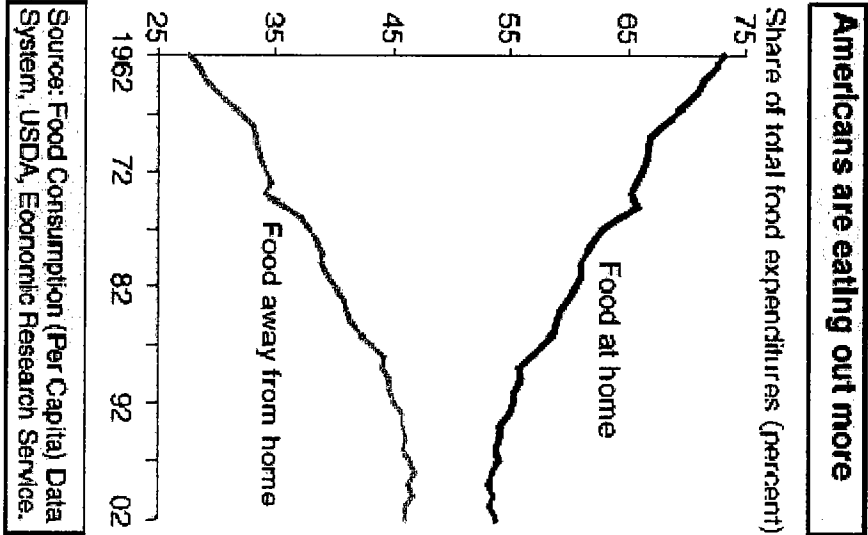
Peanut Butter and Jelly (560 cal) v. Grilled Cheese (360 cal)

Dietitians' estimates of the calorie content of popular restaurant foods

<u>food item</u>	<u>average calorie estimate</u>	<u>actual calorie content</u>	<u>percent difference</u>
Whole milk (1 c)	155	150	3% over
Lasagna (2 c)	695	960	28% under
Grilled chicken Caesar salad with dressing (4)	440	660	33% under
Porterhouse steak dinner*	1,240	1,860	33% under
Hamburger (10 oz.) and onion rings (11 rings)	865	1,550	44% under
Tuna salad sandwich (11 oz.)	375	720	48% under

*The dinner included a Porterhouse steak (untrimmed, 20 oz. before cooking) with a Caesar salad (2 cups), vegetable of the day (1 cup) and a baked potato with butter (1 tablespoon).

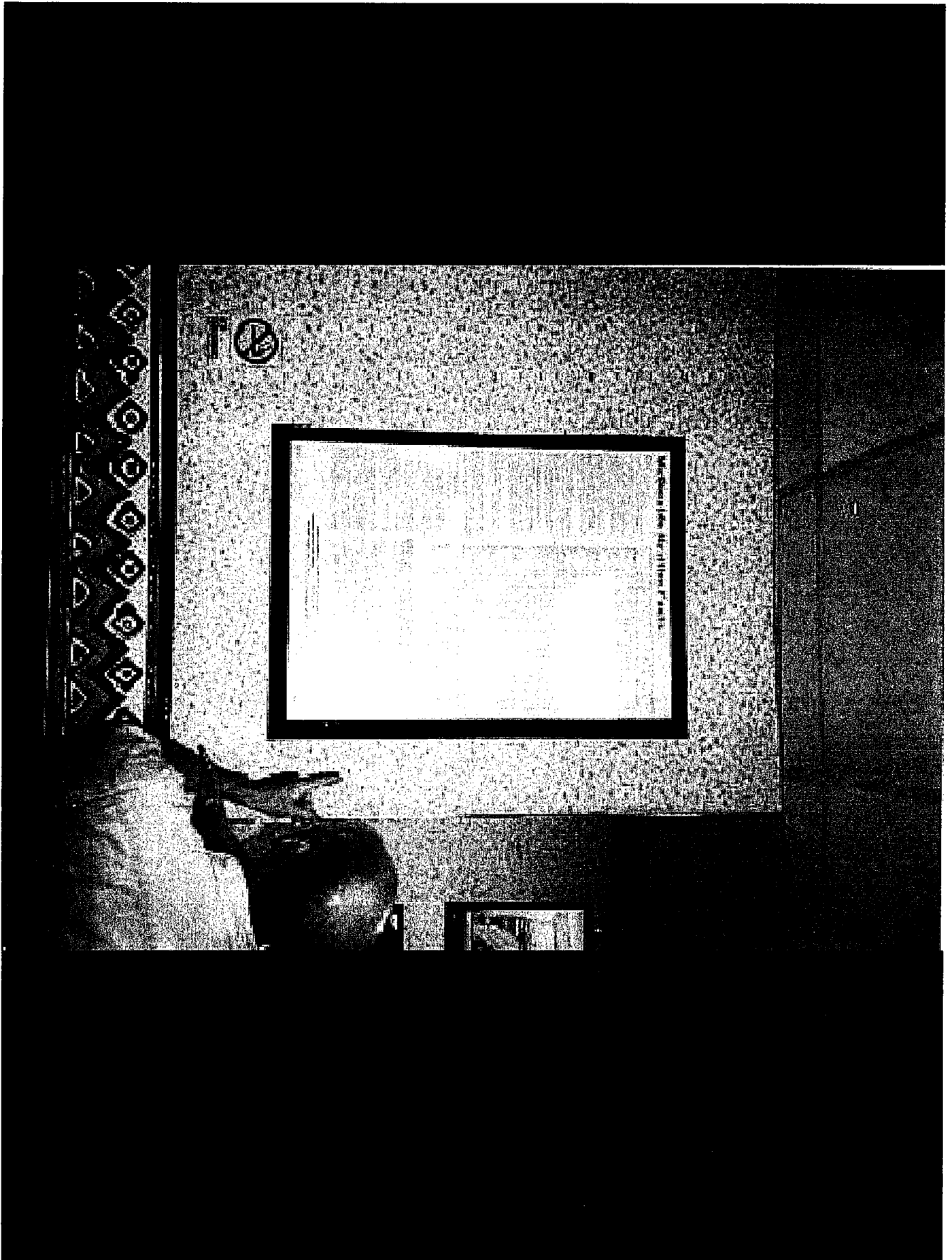
Away-from-Home Food Consumption Has Doubled



[illegible][illegible][illegible]

South West African (S.W.A.)									
Club	Year	Club	Year	Club	Year	Club	Year	Club	Year
Beaufort West	1901	Beaufort West	1902	Beaufort West	1903	Beaufort West	1904	Beaufort West	1905
Beaufort West	1906	Beaufort West	1907	Beaufort West	1908	Beaufort West	1909	Beaufort West	1910
Beaufort West	1911	Beaufort West	1912	Beaufort West	1913	Beaufort West	1914	Beaufort West	1915
Beaufort West	1916	Beaufort West	1917	Beaufort West	1918	Beaufort West	1919	Beaufort West	1920
Beaufort West	1921	Beaufort West	1922	Beaufort West	1923	Beaufort West	1924	Beaufort West	1925
Beaufort West	1926	Beaufort West	1927	Beaufort West	1928	Beaufort West	1929	Beaufort West	1930
Beaufort West	1931	Beaufort West	1932	Beaufort West	1933	Beaufort West	1934	Beaufort West	1935
Beaufort West	1936	Beaufort West	1937	Beaufort West	1938	Beaufort West	1939	Beaufort West	1940
Beaufort West	1941	Beaufort West	1942	Beaufort West	1943	Beaufort West	1944	Beaufort West	1945
Beaufort West	1946	Beaufort West	1947	Beaufort West	1948	Beaufort West	1949	Beaufort West	1950
Beaufort West	1951	Beaufort West	1952	Beaufort West	1953	Beaufort West	1954	Beaufort West	1955
Beaufort West	1956	Beaufort West	1957	Beaufort West	1958	Beaufort West	1959	Beaufort West	1960
Beaufort West	1961	Beaufort West	1962	Beaufort West	1963	Beaufort West	1964	Beaufort West	1965
Beaufort West	1966	Beaufort West	1967	Beaufort West	1968	Beaufort West	1969	Beaufort West	1970
Beaufort West	1971	Beaufort West	1972	Beaufort West	1973	Beaufort West	1974	Beaufort West	1975
Beaufort West	1976	Beaufort West	1977	Beaufort West	1978	Beaufort West	1979	Beaufort West	1980
Beaufort West	1981	Beaufort West	1982	Beaufort West	1983	Beaufort West	1984	Beaufort West	1985
Beaufort West	1986	Beaufort West	1987	Beaufort West	1988	Beaufort West	1989	Beaufort West	1990
Beaufort West	1991	Beaufort West	1992	Beaufort West	1993	Beaufort West	1994	Beaufort West	1995
Beaufort West	1996	Beaufort West	1997	Beaufort West	1998	Beaufort West	1999	Beaufort West	2000
Beaufort West	2001	Beaufort West	2002	Beaufort West	2003	Beaufort West	2004	Beaufort West	2005
Beaufort West	2006	Beaufort West	2007	Beaufort West	2008	Beaufort West	2009	Beaufort West	2010
Beaufort West	2011	Beaufort West	2012	Beaufort West	2013	Beaufort West	2014	Beaufort West	2015
Beaufort West	2016	Beaufort West	2017	Beaufort West	2018	Beaufort West	2019	Beaufort West	2020
Beaufort West	2021	Beaufort West	2022	Beaufort West	2023	Beaufort West	2024	Beaufort West	2025

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641	2642	2643	2644	2645	2646	2647	2648	2649	2650	2651	2652	2653	2654	2655	2656	2657	2658	2659	2660	2661	2662	2663	2664	2665	2666	2667	2668	2669	2670	2671	2672	2673	2674	2675	2676	2677	2678	2679	2680	2681	2682	2683	2684	2685	2686	2687	2688	2689	2690	2691	2692	2693	2694	2695	2696	2697	2698	2699	2700	2701	2702	2703	2704	2705	2706	2707	2708	2709	2710	2711	2712	2713	2714	2715	2716	2717	2718	2719	2720	2721	2722	2723	2724	2725	2726	2727	2728	2729	2730	2731	2732	2733	2734	2735	2736	2737	2738	2739	2740	2741	2742	2743	2744	2745	2746	2747	2748	2749	2750	2751	2752	2753	2754	2755	2756	2757	2758	2759	2760	2761	2762	2763	2764	2765	2766	2767	2768	2769	2770	2771	2772	2773	2774	2775	2776	2777	2778	2779	2780	2781	2782	2783	2784	2785	2786	2787	2788	2789	2790	2791	2792	2793	2794	2795	2796	2797	2798	2799	2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820	2821	2822	2823	2824	2825	2826	2827	2828	2829	2830	2831	2832	2833	2834	2835	2836	2837	2838	2839	2840	2841	2842	2843	2844	2845	2846	2847	2848	2849	2850	2851	2852	2853	2854	2855	2856	2857	2858	2859	2860	2861	2862	2863	2864	2865	2866	2867	2868	2869	2870	2871	2872	2873	2874	2875	2876	2877	2878	2879	2880	2881	2882	2883	2884	2885	2886	2887	2888	2889	2890	2891	2892	2893	2894	2895	2896	2897	2898	2899	2900	2901	2902	2903	2904	2905	2906	2907	2908	2909	2910	2911	2912	2913	2914	2915	2916	2917	2918	2919	2920	2921	2922	2923	2924	2925	2926	2927	2928	2929	2930	2931	2932	2933	2934	2935	2936	2937	2938	2939	2940	2941	2942	2943	2944	2945	2946	2947	2948	2949	2950	2951	2952	2953	2954	2955	2956	2957	2958	2959	2960	2961	2962	2963	2964	2965	2966	2967	2968	2969	2970	2971	2972	2973	2974	2975	2976	2977	2978	2979	2980	2981	2982	2983	2984	2985	2986	2987	2988	2989	2990	2991	2992	2993	2994	2995	2996	2997	2998	2999	3000
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HOT & FRESH FOOTSTED

Subs From The Oven!

Cal		6" Sub or Wrap
6" sub / wrap		
560	Meatball Marinara	<u>2.99</u>
450	Italian B.M.T.®	<u>3.69</u>
480	Spicy Italian	<u>3.29</u>
400	Steak & Cheese	<u>4.29</u>
380	Subway Melt®	<u>3.69</u>
580	Chicken & Bacon Ranch	<u>3.69</u>

Hungrier? Make it a FOOTLONG!



Italian B.M.T.®

Menu Board in NYC

Policies introduced

- Chicago
- DC
- Montgomery Cty, MD
- Philadelphia
- Nassau Cty, NY
- Westchester Cty, NY

- AZ
- CA
- CT
- HI
- IL
- ME
- MA
- MI
- NJ
- NM
- NY
- PA
- TN
- VT
- WA

CREATE A COMBO

1 1/4 LB. SINGLE



\$4.59
SMALL COMBO
930 CAL
\$2.59
SANDWICH
430 CAL

3 3/4 LB. TRIPLE



\$6.69
SMALL COMBO
1480 CAL
\$4.89
SANDWICH
980 CAL

5 ULTIMATE CHICKEN GRILL




\$5.59
SMALL COMBO
820 CAL
\$3.79
SANDWICH
320 CAL

2 1/2 LB. DOUBLE




\$5.59
SMALL COMBO
1200 CAL
\$3.89
SANDWICH
700 CAL

1 BIG BACON CLASSIC



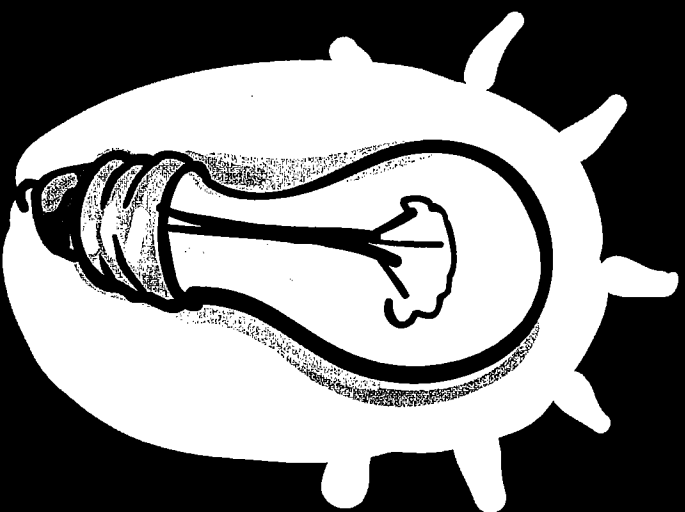
\$5.19
SMALL COMBO
1090 CAL
\$3.49
SANDWICH
590 CAL

6 SPICY CHICKEN FILLET



\$5.59
SMALL COMBO
940 CAL
\$3.79
SANDWICH
440 CAL

80% support
menu labeling in
chain
restaurants



Nutrition Labeling and Education Act

Nutrition Facts

Serving Size 1 Bar (60g)
Servings Per Container 6

Amount Per Serving

Calories 160 **Calories from Fat** 70

% Daily Value*

Total Fat 8g **12%**

Saturated Fat 5g **25%**

Trans Fat 0g

Cholesterol 5mg **2%**

Sodium 45mg **2%**

Total Carbohydrate 21g **7%**

Dietary Fiber 3g **12%**

Sugars 15g

Protein 3g

Vitamin A 4% • **Vitamin C** 0%

Calcium 10% • **Iron** 0%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2400mg	2400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

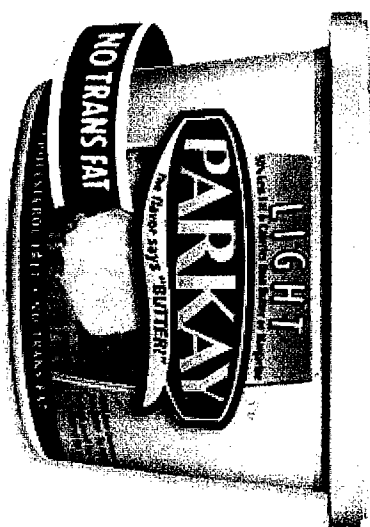
Nutrition Facts

Serving Size 2 cakes (61g)
Servings Per Container 6

	Amount Per Serving	%DV*
Calories	260	
Calories from Fat	110	
Total Fat	12g	18%
Saturated Fat	3g	14%
Trans Fat	4g	
Cholesterol	15mg	5%
Sodium	180mg	7%
Total Carbohydrate	39g	13%
Dietary Fiber	1g	2%
Sugars	30g	
Protein	1g	
Vitamin A		0%
Vitamin C		0%
Calcium		2%
Iron		6%

*Percent Daily Values are based on a 2,000 calorie diet.
Your daily values may be higher or lower depending on your calorie needs.

Total Fat	Less than 65g	2,000	2,500
Saturated Fat	Less than 20g		80g
Cholesterol	Less than 300mg		250mg
Sodium	Less than 2,400mg		300mg
Total Carbohydrate	300g		2,400mg
Dietary Fiber	25g		375g
			30g





lingu cocktail sauce. \$22.99

Striped Key West cal. 370

Two skewers of plump shrimp are dusted with Cajun spices, then broiled and seasoned with a zesty lime splash. We serve the shrimp with roasted broccoli florets for a main course that's big on flavor. \$22.99

Fish & Chips cal. 1010

Served with fries and tartar sauce. \$19.99

Grilled Cedar Salmon cal. 690

Our own cedar smoke seasoning brings inspiration. Serve to a grill, grilled 7-oz. salmon fillet, wonderfully complemented by sautéed vegetables. \$22.99

Honey Pecan Salmon cal. 830

We top a fire-grilled, cedar smoke-seasoned 7-oz. salmon fillet with pecan honey butter, then add a spoonful of glazed pecans and serve it with savory rice and vegetables. A savory and smoky blend of mouthwatering flavors and textures. \$22.99

All's Fish Tacos cal. 840

Three flour tortillas filled with crispy, mayo-coated fish, lettuce, lettuce, corn salsa and creamy lemon oil romesco sauce. Served with a side of tortilla chips and salsa. \$19.99

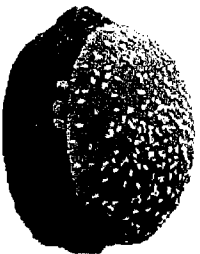
100% JUICE, 100% FRUIT, 100% TASTE. ONLY AT FRIDAY'S.

Anyone's Guess

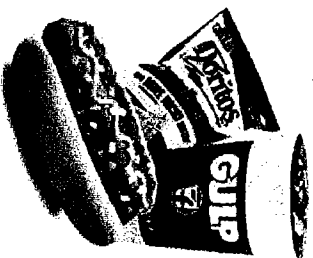
The Need for Nutrition Labeling at Fast-Food and Other Chain Restaurants



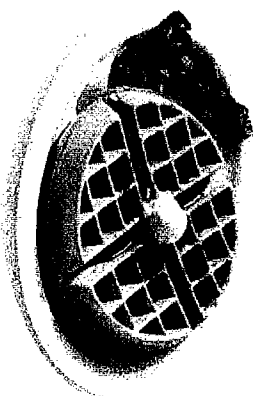
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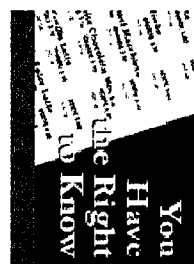
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Report at: www.cspinet.org



Menu Labeling

CHIEF FOR SCIENCE IN THE PUBLIC INTEREST



HOT TOPICS

WHAT'S NEW

Help Bring Menu Labeling to Your State

Resources/Background

Why Menu Labeling?

State & Local Bills

2007
2005-2006
2003-2004
Model Legislation
Model Regulations

Join Us

Circulate Petitions



Video: Dr. Margo Woatan explains how menu labeling informs dining-out choices.



New York Times Blog: Readers comment on calorie labeling

Menu Labeling Urged for Montgomery Co, Md., and DC
In Seattle, Menu Labeling Is "In," Trans Fat Is "Out"
Subway First to List Calories on Menu Boards in Country

More than twenty states, cities and counties are considering legislation and regulations that would require fast food and other chain restaurants to provide calories and other nutrition information on menus and menu boards. Contact us for help implementing a policy in your area: nutritionpolicy@cspline.org.

Subway added helpful calorie information to its menu boards. See model menus that could be used at Starbucks, McDonald's, Haagen Dazs, Dunkin' Donuts, Auntie Anne's, and Wendy's.

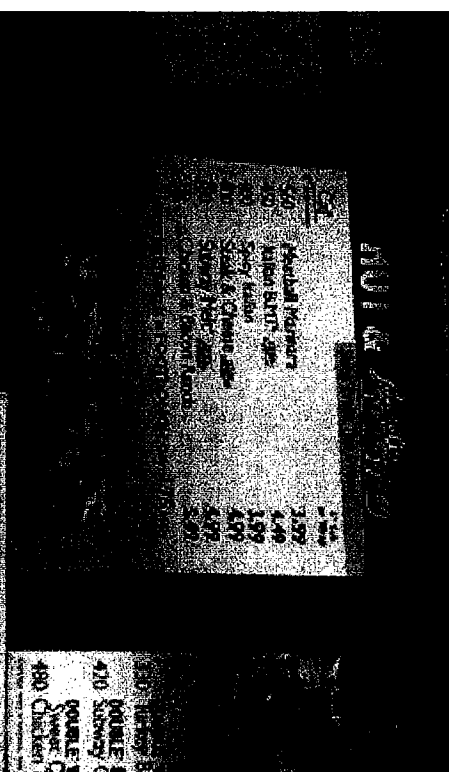
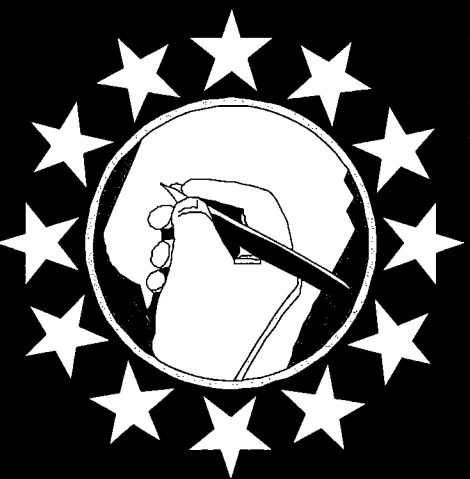


Photo of actual menu board inside a New York City Subway restaurant, 2007.

www.menulabeling.org

Ways to Support Menu Labeling

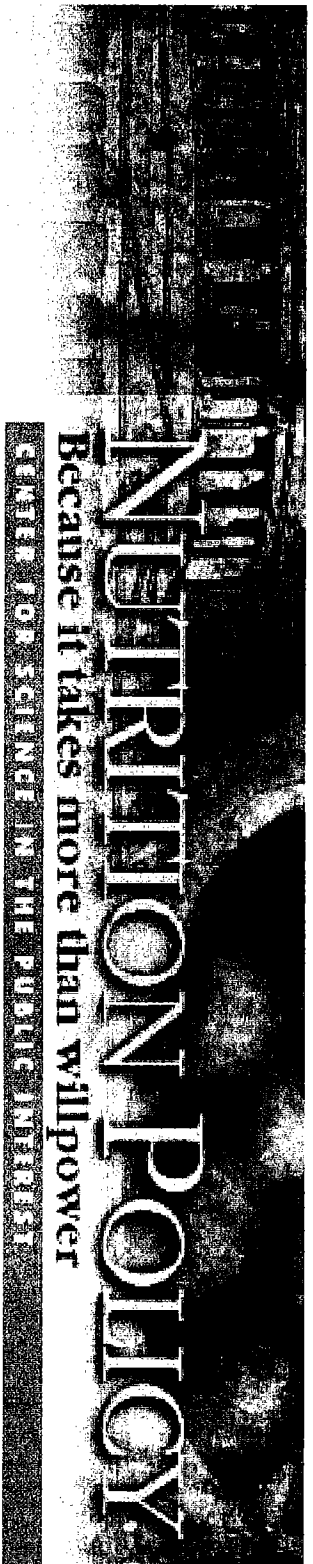
- Develop a fact sheet, educational materials on eating out
- Conduct study to estimate state-wide impact of menu labeling (like LA & NYC)
- Work with state coalition -- urge outside organization to take the lead
- Work with DoH Commissioner/Governor to support menu labeling
- Allow you to support state bill
- Develop menu labeling regs



Thursday, October 17, 2002 SANTA CRUZ SENTINEL

OPINION





Why Policy:
Why nutrition policy is important

Policy Options:
Policies and programs to promote nutrition and physical activity

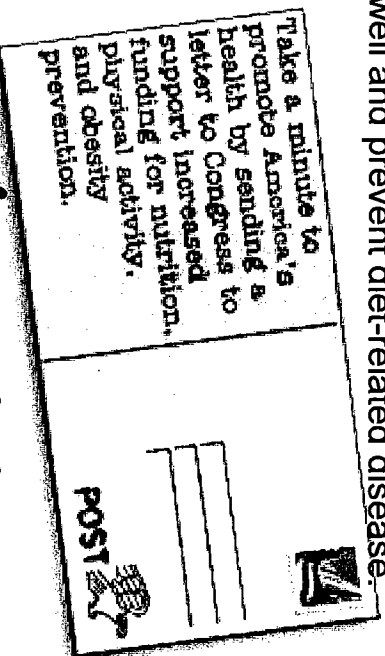
Get Involved:
What you can do

Find Out More:
Why its hard to eat well and be active in America today

The National Alliance for Nutrition and Activity
Learn more about how to eat well

Public policy can make it easier for Americans to eat well and be active

- Eating well and being physically active takes more than just willpower. We need programs and policies that make healthy food more available, that disclose the calorie content of restaurant foods, and that teach people how to make healthy eating easier. There are existing nutrition policies and programs, like Nutrition Facts labels on packaged foods, nutrition standards for school lunches, and regulation of food additives. But more needs to be done to help people who want to eat well and prevent diet-related disease.



www.cspinet.org/nutritionpolicy